P.O. Box 19909
Houston, TX 77224-1909
855-645-8448
https://healthplan.memorialhermann.org/

LARGE EMPLOYER GROUP
SELECT 1500-80
A PREFERRED PROVIDER
MAJOR MEDICAL PLAN

CERTIFICATE OF COVERAGE YEAR: 2026

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT WITH YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Si necesita ayuda en español para entender este documento, puede solicitaría sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

In consideration of Your Group's complete and accepted Application and timely payment of required Premiums, Memorial Hermann Health Insurance Company ("MHHIC") agrees with You and the Employer Group ("Group"), to provide coverage for Benefits and services, in accordance with the terms, conditions, rights, and privileges set forth in this Certificate of Coverage. You and/or Your enrolled Dependents are covered under and are subject to all the conditions and provisions noted throughout this Certificate of Coverage.

In consideration of MHHIC's agreement to provide the health care services specified in this Certificate of Coverage and subject to the terms stated herein, You promise to pay all required payments when due, abide by all of the terms of this Certificate of Coverage and comply with all applicable local, state, and federal laws.

Have a Complaint or need help?

If You have a problem with a Claim or Your Premium, call Your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a Complaint with the Texas Department of Insurance, You should also file a Complaint or Appeal through Your insurance company or HMO. If You don't, You may lose Your right to Appeal.

Memorial Hermann Health Insurance Company
To get information or file a Complaint with Your insurance company or HMO:
Call: Customer Service at 855-645-8448
Toll-free: 855-645-8448
Email: MHHPCustomerService@apex4health.com
Mail: P.O. Box 19909, Houston, TX 77224-1909

The Texas Department of Insurance
To get help with an insurance question or file a Complaint with the state:
Call with a question: 1-800-252-3439
File a Complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Memorial Hermann Health Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Servicio al cliente 855-645-8448
Teléfono gratuito: 855-645-8448
Correo electronico: MHHPCustomerService@apex4health.com
Dirección postal: P.O. Box 19909, Houston, TX 77224-1909

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

CONTACT INFORMATION

Address:	P.O. Box 19909 Houston, TX 77224-1909
Website:	https://healthplan.memorialhermann.org/
Customer Service:	855-645-8448
Provider Directory:	https://healthplan.memorialhermann.org/members/
Utilization Review for Medical Claims:	1-855-645-8448
To Report Fraud, Waste, or Abuse: Compliance Helpline: Or Report Online:	 877-448-4140 or 713-338-4140 https://memorialhermann.ethicspoint.com
For Benefits, Claims Status or Authorization Requirements:	855-645-8448
Or write to:	Memorial Hermann Health Plan P.O. Box 20167 Tampa, FL 33622-0167

For Prescription Drug Benefits contact Capital Rx

Customer Service, Preferred Drug List & Utilization Review:	833-502-3346
Prior Authorization Department and Appeals of Utilization Review:	833-502-3346
Prior Authorization Department and Appeals of Utilization Review FAX Line:	833-434-0563
For Out-of-Network Pharmacy Claim Forms & Claim Submissions, write to:	Capital Rx 9450 SW Gemini Dr., #87234 Beaverton, OR 97008
Member Portal:	https://app.cap-rx.com/?client=mhhpgrp
For Mail Orders, write to:	Costco Mail Order Pharmacy 260 Logistics Ave., Suite B Jeffersonville, IN 47130-9839
Customer Service:	1-800-607-6861
Website:	https://www.costco.com/pharmacy/home-delivery

For Specialty Pharmacy Benefits

Pharmacy: Memorial Hermann Specialty Pharmacy
21501 Park Row Dr., Ste. 200
Katy, TX 77449

Customer Service: 833-234-MHSP (833-234-6477)

Fax Number: 713-704-3841

Website: https://www.memorialhermann.org/services/specialties/specialty-pharmacy/specialties

Pharmacy: Costco Specialty Pharmacy

Member Services: 866-443-0060

Fax Number: 800-644-1180

For Mental Health Benefits contact Memorial Hermann Health Plan

Website: https://www.liveandworkwell.com/content/en/member.html

Customer Service, Verify Eligibility, Authorization Requirements & Claims Status: 855-645-8448

For Claim Forms & Submissions, write to: Memorial Hermann Health Plan
P.O. Box 20167
Tampa, FL 33622-0167

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THE SCHEDULE OF BENEFITS FOLLOWS THIS CERTIFICATE OF COVERAGE.

INTRODUCTION

Understanding Your Coverage

Hello! Thank You for purchasing this health Benefits Certificate of Coverage from Memorial Hermann Insurance Company ("MHHIC") regulated by the Texas Department of Insurance.

We take pride in providing You and Your Dependents with the Benefits described in this Certificate of Coverage. Keep this document with Your other important papers so it is available for future reference.

This health Benefit Certificate of Coverage replaces any others previously issued to You and/or Your Dependents, as of the stated or amended Effective Date. This Certificate of Coverage describes Your Benefits, rights and responsibilities covered under this Certificate of Coverage. <u>We encourage You to read this entire Certificate of Coverage carefully.</u>

Please call Us if You have questions about Your coverage, or any limits to the coverage available to You. Please be aware that Your Physician does not have a copy of Your Certificate of Coverage, and is not responsible for knowing or communicating Your Benefits to You.

Except for necessary technical terms, We use common words to describe the Benefits provided under this Certificate of Coverage. "MHHIC," "We," "Us," "Our" and "the Company" means Memorial Hermann Health Insurance Company "You", "Your", "Yourself ", "Policy Holder", "Certificate of Coverage Holder" or "Member" means You the Subscriber and/or Your enrolled Dependent.

This Certificate of Coverage contains many important terms that are defined in the **DEFINED TERMS** chapter of the document. <u>Please review the **DEFINED TERMS** chapter first</u> and be sure that You understand the meanings of these words as they pertain to this Certificate of Coverage. **C**apitalized words found throughout the document are defined in the **DEFINED TERMS** chapter.

MHHIC has issued a Policy to the Group identified on Your identification card. The Benefits and services listed in this Certificate of Coverage will be provided for Members for a covered Illness, Injury, or condition, subject to all of the terms and conditions of the Group's Policy. This Certificate of Coverage is a part of that Policy, and is subject to any terms and conditions contained in that Policy.

We are entering into this Certificate of Coverage with You based on the answers submitted by You and all other Members on Your signed Enrollment Form. In consideration for the payment of the Premiums stated in this Certificate of Coverage, MHHIC will provide the stated services and Benefits listed for all Members that are eligible and accepted.

This Coverage and the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (the Affordable Care Act) were signed into law in March, 2010. Many of the provisions of the Affordable Care Act became effective in 2014. This coverage is compliant with and subject to the Affordable Care Act and covers all Essential Health Benefits required by law.

Covered Services

Under the terms and conditions of this Certificate of Coverage, You will receive Covered Services considered by Us to be:

- Medically Necessary,
- Listed as a Covered Service,
- Not in excess of any Benefit Limitations as described in the **SCHEDULE OF BENEFITS** chapter of this Certificate of Coverage, and
- Received while Your Certificate of Coverage is in force.

Please see the SCHEDULE OF BENEFITS for Benefit specifications.

The Memorial Hermann Health Insurance Company's PPO Provider Network

MHHIC Members are able to choose which Providers will render their care. Nothing in this Certificate of Coverage restricts or interferes with Your right to select the Hospital or Physician of Your choice. In addition, nothing in this Certificate of Coverage restricts Your right to receive, at Your expense, any treatment not covered. However, Your choice(s) will determine the amount, if any, that MHHIC will pay for rendered Covered Services.

The MHHIC PPO Network consists of a broad number of Physicians, Hospitals, and other allied health professionals. Those that have partnered with MHHIC are considered Network Providers. Those not contracted with MHHIC are considered Out-of-Network Providers. Differences between the two are described below.

Network Providers

Network Physicians, Hospitals and other allied health professionals are those who have contracted with Us to participate in Our exclusive health care system to render Covered Services to our Members. These Providers have agreed to accept a negotiated amount (an "Allowable Charge") as payment in full for Covered Services provided to Members. When a Member uses a Network Provider, this Allowable Charge is used to determine the amount MHHIC pays for Medically Necessary Covered Services. When using Network Providers, Members will only be responsible for applicable Cost Sharing requirements, such as Copayments, Coinsurance or Deductibles, and will not be subject to Balance Billing.

To obtain the highest level of Benefits available, Members should always verify if a chosen Hospital or health care professional is a current MHHIC Provider before service is rendered. Members can search for Providers online at https://healthplan.memorialhermann.org/find-a-doctor?network=Select+PPO, or call Our Customer Service Department at 855-645-8448 for an up-to-date Provider listing.

Members should confirm a Provider's in-network status each time before obtaining services as Provider status may change from time to time. It is also possible that a Provider may be contracted with MHHIC to perform services at one location, and be considered out-of-network when rendering services at another location. When a Provider performs services that are not contracted with Us to perform (such as certain high-tech diagnostic or radiology procedures), Claims for those services will be paid at the out-of-network level, which may result in significant additional costs.

Out-of-Network Providers

MHHIC Provider Network is extensive and should meet the needs of most Members. However, Members can still choose Providers who are not part of Our Network to render their care. Care obtained outside Our Network means the Member will have higher Out-of-Pocket costs and pay a higher Copayment, Deductible, and/or Coinsurance than if they had stayed in-network. These additional costs may be significant.

MHHIC will pay a lower level of Benefits to Out-of-Network Providers based on a lower Allowable Charge. In addition, We only pay a portion of those charges, and it is Your responsibility to pay the remainder. We recommend that You ask Out-of-Network Providers to explain their billed charges to You, before You receive care.

Balance Billing is prohibited by Providers for certain out-of-network services: Emergency care, services provided in an in-network facility, and diagnostic imaging or laboratory services performed in connection with an in-network service. For applicable Claims, We will provide a prompt reimbursement at the Usual and Customary Rate or at an agreed rate. Your financial responsibility is limited to the applicable Copayment, Coinsurance, and Deductible based on the Plan's initial Allowed Amount.

It is the Member's responsibility to check and verify that the service(s) wanted are in-network from the Provider and location where they are seeking care.

DEFINED TERMS

The following definitions contain the meanings of key terms used in this Certificate of Coverage.

Accidental Injury – An accidental bodily Injury sustained by a Covered Person which is the direct cause of a loss independent of disease, bodily infirmity, or any other cause.

Active Employee – An Employee who is on the regular payroll of the Employer and who is performing the duties of his or her job with the Employer on a full-time basis, unless absence is due to a health status-related factor.

Acquired Brain Injury -
A neurological insult to the brain, which is not hereditary, congenital, or degenerative and the Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. For purposes of the Acquired Brain Injury Benefit, the following definitions apply:

- **Cognitive Communication Therapy** - services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- **Cognitive Rehabilitation Therapy** - services designed to address therapeutic cognitive activities, based on an assessment, and understanding of the individual's brain-behavioral deficits.
- **Community Reintegration Services** - services that facilitate the continuum of care for an affected individual as they transition into the community.
- **Neurobehavioral Testing -** an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, Family, or others.
- **Neurobehavioral Treatment -** interventions that focus on behavior and the variables that control behavior.
- **Neurocognitive Rehabilitation** - services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- **Neurocognitive Therapy -** services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.
- **Neurofeedback Therapy** - services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and that are designed to result in improved mental performance and behavior, and stabilized mood.
- **Neurophysiological Testing** - an evaluation of the function of the nervous system.
- **Neurophysiological Treatment** - interventions that focus on the function of the nervous system.
- **Neuropsychological Testing** - the administration of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- **Neuropsychological Treatment** - interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- **Post-Acute Care Treatment Services -** services provided after Inpatient care and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, that include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanism.
- **Post-Acute Transition Services** - services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- **Psychophysiological Testing** - an evaluation of the interrelationship between the nervous system and other bodily organs and behavior.
- **Psychophysiological Treatment -** interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- **Remediation -** the process of restoring or improving a specific function.
- **Services for Acquired Brain Injury** - the work of testing, treatment and providing therapies to an individual with an Acquired Brain Injury.
- **Therapy for Acquired Brain Injury** - the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Acute – The onset of disease or Injury, or a change in condition that would require prompt medical attention.

Acute Care –Care that is generally provided for a short duration to treat a serious Injury or episode of Illness or following Surgery. The care may be provided in an Inpatient setting such as a Hospital or on an Outpatient basis such as in an Emergency room.

Admission – The period from entry (Admission) into a Hospital or Skilled Nursing Facility or Unit for Inpatient care, until discharge. In counting days of care, the date of entry and the date of discharge are counted as one day.

Adverse Determination – A determination by a Utilization Review agent that health care services provided or proposed to be provided to a patient are not Medically Necessary, not appropriate or are Experimental or Investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent Utilization Review.

Allowed/Allowable Amount, Charge, or Expense – The lesser of the billed charge or the amount established by MHHIC or negotiated as the maximum amount the Plan will pay for all Provider services covered. For services rendered by Out-of-Network Providers, Plan must pay the Claim, at minimum at the Usual Customary, and Reasonable Rate (UCR) or based on Claims data, and the Covered Person may be responsible for the remaining balance. Only the Allowed Amount will be applied to Covered Person Cost Sharing accumulations.

Ambulance Service (Ambulance) –Transportation by a specially designed Emergency vehicle for transporting the sick and injured. The vehicle must be equipped as an Emergency transport vehicle and staffed by trained ambulance personnel as required by appropriate state and local laws governing an Emergency transportation vehicle.

Ambulatory Surgical Center – A specialized institution that meets all the following requirements:

- It is permanently established, equipped, and operated solely to accommodate the performance of Outpatient Surgery by Physicians who are legally authorized to perform Surgery;
- It has at least two operating rooms and at least one recovery room; is equipped to perform diagnostic lab and x-ray procedures in connection with Surgery; has resuscitation equipment for emergencies resulting from Surgery, a blood bank and other blood supplies;
- It has the full-time services of Registered Nurses for patient care in operating and recovery rooms;
- It has a written agreement with one or more Hospitals in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
- It has an organized medical staff supervising its operations as required by established policy and maintains adequate medical records for all patients.

Anniversary Date – The annual anniversary of the Policy Effective Date.

Annual Open Enrollment Period – A period of at least thirty-one (31) days consisting of an entire calendar month beginning on the first day of the month and ending on the last day of the month. If the month is less than a 31-day month, the 31-day enrollment period shall continue into the next month.

Appeal – A request from You or Your authorized representative to reconsider an Adverse Determination made by MHHIC.

Application – Any document(s) that must be completed by or on behalf of a Group applying for coverage through MHHIC.

Authorization (Authorized) – A determination by MHHIC regarding an Admission, continued Hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care setting, or level of care and effectiveness. An Authorization is not a guarantee of payment, (for example: coverage must be active on the date of service and the Provider must submit a clean Claim, etc.). Additionally, an Authorization is not a determination about the Member's choice of Provider.

Autism Spectrum Disorder (ASD) – A neurobiological disorder that includes Autism, Asperger's Syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified.

Balance Bill – A bill for services rendered by a Provider in which the amount of the billed charges are in excess of the Negotiated Rate for the Covered Services performed.

Benefits – Coverage for health care services, treatment, procedures, equipment, Drugs, devices, items, or supplies provided under this Certificate of Coverage. A schedule of all health care services that are available to Members under this Plan, including any Copayments or Deductibles and a description of where and how to obtain services. Benefits provided by Us are based on the Allowable Charge for Covered Services.

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some Biosimilars may be substituted for the original biological product at the Pharmacy without needing a new Prescription (See "**Interchangeable Biosimilar**").

Brand Name Drug – A Prescription Drug that has been patented.

Calendar Year – January 1st through December 31st of the same Year.

Certificate of Coverage, or "Certificate" – This document, explains the covered Benefits and related cost sharing responsibilities and includes the Enrollment Form, **SCHEDULE OF BENEFITS**, and any amendments/endorsements to this document, enabling a Subscriber and any applicable Dependents to use the specified health coverage contained herein.

Chemical Dependency – The abuse of or psychological or physical dependence on or addiction to alcohol, a toxic inhalant or substance designated as a controlled substance in the Texas Health and Safety Code.

Chemical Dependency Treatment Center – A facility that provides a program for the treatment of Chemical Dependency pursuant to approval by MHHIC or its designated behavioral health administrator. The facility must be:
- affiliated with a Hospital with an established system for patient Referral;
- accredited as such a facility by the Joint Commission;
- licensed, certified, or approved as a Chemical Dependency Treatment Program or center by an agency of the State of Texas having legal authority to so license, certify or approve; or
- if outside Texas, licensed, certified, or approved as a Chemical Dependency Treatment Program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify or approve.

Child/ren – Persons including Newborns, under 26 years of age or persons who are disabled as described under the *Special Needs/Dependent Children over 26* provision. A Child may be:
- born of the Subscriber; or
- legally placed for adoption with the Subscriber; or
- legally adopted by the Subscriber; or
- if the Subscriber is a party to a suit in which the Subscriber seeks to adopt the Child; or
- for whom the Subscriber or his legal Spouse has been granted legal custody or appointed as guardian ad litem; or
- supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or
- a stepchild of the Subscriber; or
- a grandchild who is under the age limit of the Certificate of Coverage and is a Dependent of the Subscriber for federal income tax purposes at the time of Application.

Chronic – Pertaining to a disease, Illness, or Injury that persists for a long time or is constantly recurring**.**

Claim – Written or electronic proof, in a form acceptable to MHHIC of charges for Covered Services that have been incurred by a Member during the time period when covered under this Certificate of Coverage. The provisions in effect at the time the service or treatment is received will govern the processing of any Claim expense actually incurred as a result of the service or treatment rendered.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance – The sharing of eligible Allowable Charges for Covered Services between MHHIC and a Covered Person. The sharing is expressed as a pair of percentages, a percentage that We pay, and a percentage that You

pay. Once the Covered Person has met any applicable Deductible amount, Your percentage will be applied to the Allowable Charges for Covered Services to determine Your financial responsibility. Our percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Community Reintegration Services – Services that facilitate the continuum of care as an affected individual transitions into the community.

Complaint – Any dissatisfaction expressed either orally or in writing by a complainant to an insurer regarding any aspect of their operation, including: dissatisfaction relating to Plan administration, procedures related to review or Appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to Medical Necessity, the manner in which a service is provided, and a disenrollment decision.

Contract– The entire Contract between the Group and Us is as stated in the Policy and the Certificate of Coverage including the endorsements, Application, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of Our officers. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.

Copayment (Copay) – The specific dollar amount a Covered Person must pay when specified Covered Services are rendered, as shown on the **SCHEDULE OF BENEFITS**. The Copayment may be collected directly from a Covered Person by a Network Provider. Copayments do not count towards any Deductible.

Cosmetic and Reconstructive Surgery – **Cosmetic Surgery** is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Reconstructive Surgery** is Surgery to correct abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infections, tumors, or disease. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Cost Sharing – Amounts You must pay for Covered Services, expressed as Coinsurance, Copayments and/or Deductibles when applicable.

Course of Treatment – A planned, structured, and organized sequence of treatment procedures based on an individualized evaluation to restore or improve health function, or to promote chemical free status. A Course of Treatment is complete when the Covered Person has finished a series of treatments without a lapse in treatment or has been medically discharged. If the Covered Person begins a series of treatments, it will count as one (1) Course of Treatment, reducing the available Benefits, even if the Covered Person fails to comply with the treatment program for a period of thirty (30) days.

Covered Charges (Covered Expenses) – The expenses incurred for Covered Services.

Covered Person – Any Eligible Employee or Eligible Dependent whose primary residence is covered under this Plan.

Covered Services – Medically Necessary health services, including Prescription Drug services, specified and described in the **COMPREHENSIVE MEDICAL BENEFITS AND SERVICES** and **PRESCRIPTION DRUG BENEFITS** chapters of this Certificate of Coverage that are available when rendered by a Provider and for which the Covered Person is entitled to receive Benefits.

Crisis Stabilization Unit – A 24-hour residential program that is usually short term in nature and provides:

- intensive supervision; and
- highly structured activities to persons who are demonstrating an Acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care – Care provided primarily to meet a Covered Person’s personal needs. This includes help with walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administration of medicine that is usually self-administered, or any other care that does not require continuing services of a medical professional.

Deductible – Annually set amounts of Covered Expenses that Covered Persons must pay before We will pay for any Benefits for such charges. The Deductible cannot be met with non-covered Charges. Only Covered Charges incurred by the Covered Person can be used to meet the Deductible. The Deductible amount is shown in the **SCHEDULE OF BENEFITS**.

Once the Deductible is met, You will pay Benefits for other Covered Charges above the Covered Person's reached Deductible amount. The Deductible does not include any Copayments applicable for the rest of the Certificate of Coverage Year. All charges must be incurred while the Covered Person(s) is covered under this Certificate of Coverage.

Family Deductibles
If applicable, the Family Deductible is a cumulative amount all Family Members enrolled in this Plan must pay for each Plan Year. Although Family members incur Covered Charges independently based on the individual Deductible amount, each paid expense contributes to the cumulative Family Deductible limit.

The Family Deductible limit can be met by a combination of Family Members with no single individual within the Family contributing more than the Individual Deductible limit amount in a Plan Year. Once this Family Deductible limit is satisfied for that Year, We provide coverage for all Covered Charges for all Family Members who are enrolled in the same Certificate of Coverage.

Dental Care and Treatment – All procedures, treatment, and Surgery considered being within the scope of the practice of dentistry, that is defined as a practice that:

- represents themselves as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, Injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, Injury, deficiency, deformity, or physical condition of the same; or
- takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- furnishes, supplies, constructs, reproduces, or repairs, or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

Dental Prostheses – Dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Dependents (Eligible Dependents) – An Employee's lawful Spouse, an Employee's Dependent Child through the age of 26; and, an Employee's Domestic Partner who may be the same or opposite gender as the Eligible Employee who meets the eligibility requirements as described in the **ELIGIBILITY AND ENROLLMENT** chapter of this Certificate of Coverage. Children over the age of 26 may also be Dependents under the circumstances described in the **ELIGIBILITY AND ENROLLMENT** chapter of this Certificate of Coverage.

Dependent Child – A Dependent other than an Employee's lawful or common law Spouse or Domestic Partner. A Dependent Child may be a natural Child, a grandchild, an eligible foster Child, a stepchild, a Child placed for adoption, an adopted Child (including a Child for whom the Employee or the Employee's Spouse is a party in a suit in which the adoption of the Child is sought), a Child with a medical support order, a Child of any age who is medically certified as disabled, or a Child of a Domestic Partner.

Diabetic Supplies – includes test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes for administering insulin, oral agents available with or without a Prescription for controlling blood sugar levels, and glucagon Emergency kits. As new or improved diabetes supplies become available and are approved by the United States Food and Drug Administration, such supplies shall be covered if determined to be Medically Necessary and appropriate by a licensed Provider through a written order.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures recognized by Us as accepted medical practice, rendered because of specific symptoms, and that are directed toward detection or monitoring of a definite condition, Illness, or Injury. A Diagnostic Service must be ordered by a Provider prior to delivery of the service.

Domestic Partner – An individual who may be the same or opposite gender as the Eligible Employee and has the same meaning and coverage as a "lawful Spouse." A Domestic Partner must meet the following criteria:

- at least 18 years of age or legally emancipated;
- mentally competent to consent to Contract;
- has the competency to consent to a Contract for a permanent residence and is not sharing a permanent residence with another person who has obtained the age of majority;
- has shared a common residence with the Eligible Employee for an extended period of time;
- has shared financial assets and obligations with the Eligible Employee for an extended period of time; and
- has established a domestic partnership with the Certificate of Coverage holder by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar.

Drugs (Prescription Drugs) – Prescription Drugs approved by the State of Texas or the Food and Drug Administration for general use by the public. For purposes of this Benefit, insulin is considered a Prescription Drug.

Durable Medical Equipment (DME) – Items and supplies that are used to serve a specific therapeutic purpose in the treatment of an Illness or Injury, can withstand repeated use, are generally not useful to a person in the absence of Illness, Injury, or disease, and are appropriate for use in the patient's home.

Effective Date – The date on which coverage under this Certificate of Coverage begins for the Member and/or their Dependents. This Certificate of Coverage is effective at 12:01 am on the noted Effective Date.

Eligible Employee – An Employee who meets the eligibility criteria for enrollment outlined in this Certificate of Coverage.

Emergency Admission – An Inpatient Admission to a Hospital resulting from an Emergency Medical Condition.

Emergency Medical Condition (or "Emergency") – A medical condition of recent onset and severity, including severe pain, which would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the person, or with respect to a pregnant woman, the health of the woman or fetus, in serious jeopardy;
- serious impairment to bodily function;
- serious dysfunction of any bodily organ or part; or
- serious disfigurement of such person.

Emergency Medical Services – Any health care service provided to evaluate and/or treat an Emergency Medical Condition requiring immediate, unscheduled medical care.

Employee – A person who is an active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Enrollment Form – Any document(s) which must be completed by or on behalf of a person applying for coverage.

Exclusions & Limitations – Health care services We do not pay for or cover, or which have a maximum limit to the extent of coverage.

Expedited Appeal – A request for immediate review of an Adverse Determination involving an Admission, availability of care, continued Hospital stay, or health care service for which a Member has received Emergency services, but has not been discharged from a facility or for the denial of Emergency care, Prescription Drugs, denial of a Drug step therapy exception or intravenous infusions. Used when life, limb or Member's health is immediately threatened.

Expedited External Appeal – A request for immediate review, by an External Review Organization, of an initial Adverse Determination, which involves any of the following:

- a medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function, or a decision not to Authorize continued services for Members currently in the Emergency room, under Observation, or receiving Inpatient care.

- a denial of coverage based on a determination the recommended or requested health care service or treatment is Experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Member's health, including severe pain, potential loss of life, limb, or major bodily function.
- a denial of Prescription Drugs or intravenous infusions for which the Member is receiving Benefits.
- a denial of a step therapy exception request.

Experimental and/or Investigational Procedures – Any medical, surgical, and/or other procedures, services, products, Drugs, or devices, (including implants) is considered Experimental or Investigational if:
- its use is mainly limited to use in a laboratory and/or research setting; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished, and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the stated or means of treatment or diagnosis; or
- reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the stated means of treatment of diagnosis; or
- reliable evidence shows that it is not generally approved or used by Physicians in the medical community; or
- it does not have final approval from the appropriate governmental regulatory body.

Reliable evidence means only: the published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

External Appeal – A request for review by an External Review Organization to change an initial Adverse Determination made by the Company or to change a final Adverse Determination rendered on Appeal. An External Appeal is available upon request by the Member or authorized representative for Adverse Determinations involving Medical Necessity, appropriateness of care, health care setting, level of care, provision of Prescription Drugs or intravenous infusions, effectiveness, Experimental or Investigational treatment, step therapy exceptions, or a Rescission. External Appeals are not available for Benefit evaluation or review of non-covered Benefits.

External Review Organization – An External Review Organization, not affiliated with Us, that conducts External Reviews of final Adverse Determinations. The decision of the External Review Organization is binding on both the Member and the Company.

External Review – A review by a person or a third party that is not associated with or affiliated with the Employer or MHHIC. An External Review may be conducted to review Adverse Determinations or Appeals.

Facility-Based Provider – A healthcare Provider who offers medical services exclusively within licensed health facilities.

Family – The covered Employee and the Family members who are covered as Dependents under the Certificate of Coverage.

Foreign Country Provider – Any institutional or professional Provider of medical or psychiatric treatment or care who practices in a country outside the United States of America. A Foreign Country Provider may also be a supplier of medical equipment, Drugs, or medications.

Formulary (Drug List) – A listing developed by the Pharmacy and Therapeutics Committee and reviewed quarterly, of Drugs which available medical literature indicates are clinically effective and safe while being reasonable in cost.

Formulary Drug – A Drug included on the Certificate of Coverage Prescription Drug Formulary. A Preferred Drug is usually covered under the Certificate of Coverage without the need for Prior Authorization.

Generic Drug – A Drug that has the same active ingredient as the Brand Name Drug and that may be produced after the Brand Name Drug's patent has expired. Generic Drugs are shown on the Prescription Drug Formulary (the list of covered Prescription Drugs) which is available at https://healthplan.memorialhermann.org/members/resource-center/pharmacy-benefit-information/.

Genetic Information – Information about genes, gene products, and inherited characteristics that may derive from an individual or a Family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories and direct analysis of genes or chromosomes.

Grace Period – The amount of time after the Premium is due, during which payment can still be made without coverage lapsing.

Grievance – A written expression of dissatisfaction with MHHIC or with Our Provider services that does not involve a Utilization Review determination.

Group – The business entity to which We have issued the Policy.

Habilitative Care– Health care services that help a person to develop skills and functioning for daily living that they are incapable of developing on their own. These services may include Physical and Occupational Therapy and Speech-Language Pathology .

Home Health Care – Health services rendered in the individual's place of residence by an organization licensed as a Home Health Care agency by the appropriate state agency and approved by Us. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse (R.N.) licensed to practice in the state.

Hospice(s) – Licensed Providers according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as Hospice Providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospice Care Plan – Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Members during the final stages of terminal Illness. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency approved by Us.

Hospital – An institution that meets all the following requirements:

- it is operated in accordance with the laws of the jurisdiction in which it is located pertaining to Hospitals and is either accredited by The Joint Commission or certified under Medicare;
- it is primarily engaged in providing, on an Inpatient basis, diagnostic and therapeutic facilities for the diagnosis, medical care, and treatment of sick and injured persons under the supervision of a staff of Physicians for compensation from its patients and on an Inpatient basis;
- it is not primarily a place for Custodial Care or a nursing or convalescent home, but it does provide all services on its premises under the supervision of a staff of Physicians; and
- it continuously provides twenty-four (24) hour a day nursing service by or under the supervision of Registered Nurses (RN's) on the premises.

Hospitalization – Care in a Hospital that requires Admission as an Inpatient and usually requires an overnight stay.

Illness – A bodily disorder, disease, physical Sickness, or mental health condition. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Immunization – The creation of immunity usually against a particular disease; treatment (as by vaccination) of an organism for the purpose of making it immune to a particular pathogen.

Individual Treatment Plan – A written plan for treatment of a Covered Person developed and implemented through a cooperative process between the Covered Person and the health care practitioner and that identifies desired treatment outcomes and strategies for achieving such outcomes.

Infertility – The inability to:

- conceive after sexual relations without contraceptives for the period of one (1) year; or
- maintain a pregnancy until fetal viability.

Infusion Therapy – The administration of Prescription Drugs by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Certificate of Coverage, it will also include Drugs administered by aerosol (into the lungs) and by feeding tube.

Initial Enrollment Period – The 31-day period during which an Eligible Employee or Eligible Dependent first qualifies to enroll for coverage.

Injury – An accidental bodily Injury caused by unexpected external means while covered under this Plan. The Injury must result in loss directly and independently of all other causes. All bodily Injuries caused by one accident shall be considered as one Injury.

Inpatient – A Member who is admitted to a Hospital as a registered bed patient for whom a bed, board, and general nursing service charge is made. An Inpatient's medical symptoms or condition must require continuous twenty-four (24) hour a day Physician and nursing intervention. If the services can be safely provided to the Member as an Outpatient, the Member does not meet the criteria for an Inpatient.

Interchangeable Biosimilar – A Biosimilar that may be used as a substitute for an original Biosimilar product at the Pharmacy without needing a new Prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the Pharmacy is subject to state law.

Large Employer – An Employer who employs an average of at least 51 Eligible Employees on business days during the preceding Calendar Year and who employs at least two employees on the first day of the Policy Year.

Legal Guardian – A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Life-Threatening Illness – A severe, serious, or Acute condition for which death is probable.

Maintenance Prescription Drugs – Prescription Drugs taken for an extended period of time to treat a long term or Chronic medical condition. When You get a long-term supply (90-day supply) of these Drugs, Your Cost Sharing may be lower. These Drugs may also be eligible for Medication Synchronization plans.

Medical Care Facility – A Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Director – Is any Physician designated by the Issuer who shall have responsibilities for assuring the continuity, availability, and accessibility of covered Benefits. These responsibilities include, but are not limited to, monitoring the programs of quality assurance, Utilization Review, and peer review; determining Medical Necessity; and determining whether a Treatment is Experimental or Investigational.

Medical Emergency/Emergency Medical Condition – A medical condition provided in a Hospital Emergency facility, freestanding Emergency Medical Care Facility, or comparable Emergency facility to evaluate and Stabilize a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that the person's condition, Sickness or Injury is of such a nature that failure to get immediate medical care could result in:

- placing the Covered Person's health in serious jeopardy;
- causing serious impairment to bodily functions;
- causing serious dysfunction of any bodily organ or part;
- causing serious disfigurement; or
- in the case of a pregnant woman, causing serious jeopardy to the health of the fetus.

Medically Necessary (Medical Necessity) – Services or supplies are those that MHHIC determines to be all of the following:

- appropriate and necessary for the symptoms, diagnosis, or treatment of the medical conditions;

- provided for the diagnosis or direct care and treatment of the medical condition;
- within standards of good medical practice within the organized medical community;
- not primarily for the patient's convenience, the Physician's, or another Provider's convenience; and
- the most appropriate procedure, supply, equipment, or service that can be safely provided must satisfy the following requirements:
    - there must be valid scientific evidence demonstrating that the expected health Benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of Benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
    - generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    - for Hospital stays, Acute Care as an Inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting.

Medicare – The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Medication Synchronization - A unique patient program designed to make it easier for a patient to pick up all their maintenance medication refills at the Pharmacy in a single convenient visit. To utilize this feature, the patient must request a Network Pharmacy to adjust their medications and coordinate the refilling of their medications to one convenient monthly medication pickup date.

Member – The Subscriber, or a covered Dependent for whom required Premiums have been paid.

Mental, Emotional or Functional Nervous Disorders – Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind as defined by generally recognized independent standards of current medical practice.

MHHIC, We, Our, and Us – Memorial Hermann Health Insurance Company is a health insurance company regulated by the State of Texas.

Negotiated Rate – The rate of payment that MHHIC has contracted with a Network Provider for Covered Services.

Network – The facilities, Providers, and suppliers Your health insurer or Plan has contracted with to provide health care services.

Network Hospital (in-network) - A Hospital that has a Network Provider agreement in effect with MHHIC at the time services are rendered. Network Hospitals agree to accept the Negotiated Rate as payment instead of their normal rate.

Network Pharmacy (in-network) - A licensed Pharmacy that has a Network Provider agreement in effect with MHHIC at the time services are rendered.

Network Physician (in-network) - A Physician who has a Network Provider agreement in effect with MHHIC at the time services are rendered. Network Physicians agree to accept the Negotiated Rate as payment instead of their normal rate.

Network Provider (in-network) **-** A Provider who has a contract with Your health insurer or Plan who has agreed to provide services to Members of the Plan at a Negotiated Rate of payment.

Newborn – A recently born infant from the time of birth until age one (1) month or until such time as the infant is well enough to be discharged from a Hospital or neonatal Special Care Unit to his or her home, whichever period is longer.
Non-Formulary Drug - is a Drug that is not included on the Formulary listing.

Observation – An Outpatient stay of generally less than forty-eight (48) hours for treatment or services in a Hospital not requiring full Inpatient support.

Occupational Therapy (OT) – The evaluation and treatment of physical Injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by the use of specific goal directed activities, therapeutic exercises and/or other interventions that alleviate impairment and/or improve functional performance.

Office Visit – A visit by the Member, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

- history (gathering of information on an Illness or Injury)
- examination
- medical decision making (the Physician's diagnosis and plan of treatment)

This does not include other services (e.g., x-rays or lab services) even if performed on the same day.

Orthotic Device – A custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Out-of-Network Hospital– A Hospital that does not have a contract with Your health insurer or Plan to provide services to Members of the Plan.

Out-of-Network Pharmacy – A Pharmacy that does not have a Network Pharmacy agreement with MHHIC at the time services are rendered. We do not require clinician-administered Drugs, or "white-bagging" products, to be dispensed under Pharmacy Benefits instead of medical Benefits, nor do We charge additional fees or higher Cost Sharing for these products outside of Our normal defined Benefits, nor require these products be dispensed by certain Pharmacies.

Out-of-Network Physician – A Physician who does not have a Network Provider agreement with MHHIC at the time services are rendered.

Out-of-Network Provider – A Provider who does not have a Network Provider agreement in effect with MHHIC at the time services are rendered.

Out-of-Pocket – The Covered Charges that a Covered Person incurs under the Plan.

Out-of-Pocket Maximum – The maximum amount, as shown on the **SCHEDULE OF BENEFITS**, of un-reimbursable expenses (including any applicable Deductible amount, Copayment and/or Coinsurance), that must be paid by a Covered Person for Covered Services in one (1) Benefit period. The Out-of-Pocket Maximum does not include certain amounts indicated on the **SCHEDULE OF BENEFITS**.

Outpatient – A Member who receives services or supplies while not in a Hospital or Acute Care setting.

Outpatient Day Treatment Services – Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Partial Hospitalization – An Outpatient program specifically designed for the diagnosis or active treatment of a mental health condition or Chemical Dependency when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse this program shall be administered in a psychiatric facility that is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than 4 hours, a day and no charge is made for room and board.

Pharmacy – A state and federally licensed establishment where the practice of Pharmacy occurs, that is physically separate and apart from any health care Provider's office, and where Prescription Drugs and devices are legally dispensed under Prescriptions to the general public by a pharmacist licensed to dispense such Prescription Drugs and devices under the laws of the state in which such pharmacist practices.

Physical Therapy (PT) – The treatment of disease or Injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Physical and/or Occupational Therapy/Medicine – The therapeutic use of physical agents other than Drugs. It comprises the use of physical, chemical, and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation, and radiation.

Physician – A doctor that is licensed to practice medicine or any other practitioner who is licensed and recognized as a Provider of health care services in the state in which services are provided; and who provides services covered by the Certificate of Coverage that are within the scope of his or her licensure.

Plan - The set of Benefits described in this Certificate of Coverage, forms, and amendments (if any).

Plan Year – The Contract period for twelve (12) consecutive coverage months, with the Effective Date on the first of the month of the first month of coverage. The Plan Year can start on the first day of any month and continue through the last day of the 12th month of coverage.

Policy – The insurance Contract issued by MHHIC to the Group as a means of providing certain Benefits to the Eligible Employees and their Eligible Dependents.

Post-Acute Care Treatment Services – Services provided after Acute Care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanism.

Post-Acute Transition Services – Services that facilitate the continuum of care beyond the initial onset through rehabilitation and community reintegration.

Preauthorization – A decision by MHHIC that health care services are Medically Necessary and appropriate. Your health insurance or Plan may require Preauthorization for certain services before You receive them, except in Emergency. Preauthorization isn't a promise Your health insurance or Plan will cover the cost.

Pregnancy Care – Treatment or services related to all care prior to delivery, delivery, post-delivery care, and any complications arising from each pregnancy.

Premium – The amount that must be paid for Your health Benefit coverage.

Prescription – A written or verbal order from a licensed health care practitioner to a pharmacist for a Drug or device to be dispensed. Any oral Prescription must be promptly recorded in writing by the Pharmacy from which it is dispensed.

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this Benefits Certificate of Coverage.

Prescription Drugs – Drugs, biological or compounded Prescriptions which are required by law to have a label stating "Caution – Federal Law Prohibits Dispensing Without a Prescription" and which are approved by the federal Food and Drug Administration (FDA) for safety and effectiveness, subject to the Prescription Drug Exclusions and Limitations.

Preventive and Wellness Care Services – Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

Primary Care Provider – A Physician or other health care Provider who is a general caregiver and includes general and family practitioners, internists, pediatricians, or other Provider who may be otherwise designated by MHHIC as a Primary Care Provider. A Primary Care Provider cannot be a Specialty Care Provider.

Prior Authorization – The Plan requires You (or Your Physician) to get Prior Authorization for certain Drugs. This means that You will need to get approval from the Plan before You fill Your Prescriptions. If You don't get approval, the Plan may not cover the Drug.

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is unrelated to the patient by blood, marriage, or adoption. These services must be ordered by the attending Physician and require the technical skills of a R.N. or L.P.N. and are generally not Covered Services.

Professional Services – The specific services rendered by an occupational therapist, physical therapist, speech pathologist or audiologist, Physician, or chiropractor for Covered Services provided.

Prosthetic Appliance or Device – Appliances that replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part. When referring to limb prostheses, it is an artificial limb designed to maximize function, stability, and safety of the patient, that is not surgically implanted and that is used to replace a missing limb. Limb prosthetics do not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services – The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, for cosmetic purposes, or both. Also includes Medically Necessary clinical care.

Provider – A Hospital, allied health facility, Physician, or allied health professional, licensed where required, performing within the scope of license, and approved by Us. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

- Network Provider – A Provider who has entered into a Contract with Us to participate in a PPO Network.
- Out-of-Network Provider – A Provider that does not have a signed Contract with Us or another MHHIC Plan.

Psychiatric Day Treatment Facility – An Outpatient psychiatric facility that:

- provides an organizational structure separate from Hospital confinement programs,
- provides no more than eight hours of treatment per patient in any 24-hour period,
- is clinically supervised by a psychiatrist, and
- is accredited by the Joint Commission on Accreditation of Hospitals.

Qualified Beneficiary – Refers, under the COBRA continuation of coverage law, to an individual covered by a Group health Plan, including this Certificate of Coverage, on the day before a Qualifying Life Event who is either an Employee, the Employee's Spouse, or an Employee's Dependent Child.

Qualifying Life Event – A change in Your situation – like getting married, having a baby, or losing health coverage – that can make You eligible for a Special Enrollment Period, allowing You to enroll in health insurance outside the Annual Open Enrollment Period.

Referral – An Authorization given to one Network Provider from another Network Provider (usually from a PCP to a Network Specialist) in order to arrange for additional care for a Member.

Rehabilitative Care – Health care services and devices that help a person to keep, resume or improve skills and functioning for daily living that have been lost or impaired because a patient was sick, hurt or disabled. These services may include Physical Therapy, Occupational Therapy, Speech/Language Pathology Therapy, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Remediation – The process of restoring or improving a specific function.

Rescission – Cancellation or discontinuance of coverage that has retroactive effect.

Research Institution – The institution or other person or entity conducting a phase I, phase II, phase III or phase IV clinical trial.

Residential Treatment Center – A twenty-four (24) hour, non-Acute Care treatment setting for the active treatment of specific impairments of mental health or substance abuse.

Retail Health (Walk-in) Clinic - A clinic that treats certain common, non-Emergency conditions, such as sinus infections or upper respiratory infections, bladder infections, strep throat, pink eye or styes, minor Injuries, such as

burns and sprains, and skin conditions, such as eczema. A clinic may be staffed by a licensed nurse practitioner or Physician Assistant, who can write a Prescription, if necessary, with a doctor, employed by the clinic, available on call to the nurse practitioner if a consultation is necessary or an Emergency arises. The clinic may be located in stores or pharmacies and may have evening and weekend hours.

Self-Administered Injectable Drugs – Injectable Drugs that are approved for self-administration by the Food and Drug Administration.

Service Area – The geographical area designated by Us and approved by the State of Texas in which We provide coverage. For this Certificate of Coverage the Service Area consists of: Brazoria, Fort Bend, Galveston, Harris, Montgomery, Walker, Waller, and Wharton counties.

Sickness – Any of the following, whether diagnosed, treated, or requiring treatment by a health care Provider: ill health, disease, pregnancy and bodily or mental infirmity or disorder, including mental/nervous problems. All Sicknesses which are due to the same cause or related cause shall be considered as one Sickness.

Skilled Nursing Facility – An institution or distinct part of an institution that is licensed or approved under state law and primarily provides skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility approved by The Joint Commission, the Bureau of Hospitals of the American Osteopathic Association or as otherwise determined by MHHIC to meet the reasonable standards applied by either one of those authorities that provides:

- bedded medical care, treatment and skilled nursing care as defined by Medicare and that meets the Medicare requirements for this type of facility;
- full-time supervision by at least one Physician or Registered Nurse;
- twenty-four (24) hour nursing service by Registered Nurses or Licensed Practical Nurses; and
- Utilization Review plans for all patients.

Special Care Unit – A designated Hospital unit that is approved by Us and that has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, such as an intermediate care neonatal unit, telemetry unit for heart patients, or an isolation unit.

Special Enrollment Period – A time outside the Annual Open Enrollment Period when You can sign up for health insurance due to a Qualifying Life Event.

Specialty Care Provider or **Specialist** – A Physician or other health care Provider who is classified as a Specialist by the American Board of Medical Specialties or who is designated by MHHIC as a Specialty Care Provider. A Specialty Care Provider cannot be a Primary Care Provider.

Specialty Drugs – High-cost Prescription Drugs that meet any of the following criteria:

- are used in limited patient populations or indications; or
- may be self-injected; or
- have limited availability, require special dispensing, or delivery and/or patient support is required; and/or Utilization Review plans for all patients.

Speech/Language Pathology Therapy (ST) – The treatment used to manage speech/language, cognitive-communication, and swallowing disorders. Goals are directed towards improving or restoring function.

Spouse – The Employee’s husband or wife, through lawful or common law marriage.

Stabilize – With respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “Stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn Child.

Subscriber – The person to whom this Certificate of Coverage is issued (also known as the Member, or Certificate of Coverage holder).

Surgery –

- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies, and other invasive procedures.
- The correction of fractures and dislocations.
- Pregnancy Care includes vaginal deliveries and cesarean sections.
- Usual and related pre-operative and post-operative care.
- Other procedures as defined and approved by Us.

Surprise Bill (Surprise Billing) – An unexpected balance bill for services performed by an Out-of-Network Provider, such as in the case of an Emergency.

Telehealth Service – A health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunication or information technology.

Telemedicine Medical Service – A health care service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

Temporomandibular Joint Disorder (TMJ) – Disorders resulting in pain and/or dysfunction of the temporomandibular/craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes.

Urgent Care Clinic – A clinic, with extended office hours, which provides urgent care and minor Emergency care to patients on an unscheduled basis and without need for an appointment. The Urgent Care Clinic does not provide routine follow-up care or Wellness examinations and refers patients back to their regular Physician for such routine care.

Usual, Customary, and Reasonable Rate (UCR) – The fee based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs.

Utilization Management – Evaluation of necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

Utilization Review – A system for prospective, concurrent, or retrospective review of the Medical Necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the Experimental or Investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Waiting Period – A required period of continuous, full-time employment that must be completed before an Eligible Employee is eligible for coverage.

Well Baby Care – Regularly scheduled, Preventive Care Services, including Immunizations, provided to Children up to age twenty-four (24) months, or as otherwise mandated by law.

Year – "Benefit Year" or "Deductible Year" - A covered period lasting for one (1) Calendar Year beginning January 1st at 12:01 a.m. (Central Standard Time) and ending on December 31st at 11:59 p.m. (Central Standard Time) unless otherwise noted. If Your coverage initially begins on a day other than January 1st, the first year will be shorter than 12 months and also end as of December 31st at 11:59 p.m. (Central Standard Time).

You, Yours – Refers to the Employee who is a Covered Person under the Certificate of Coverage.

ELIGIBILITY AND ENROLLMENT

Subscribers, who reside or work in the MHHIC Service Area and their Dependents are covered under this Certificate of Coverage. If You are enrolled in Medicare, You are not eligible to purchase or be enrolled in this Certificate of Coverage.

Types of Coverage

The Certificate of Coverage holder may elect coverage just for him/herself or may add one or more Eligible Dependents for coverage. The possible types of coverage are listed below.

- Single coverage - for only one person, the Certificate of Coverage holder.
- Family coverage - for You, Your Spouse and/or Your Dependent Child or coverage for multiple Children who share a common Legal Guardian, or for when there exists a valid medical support order requiring health Benefit coverage whether or not there is an adult who will be provided coverage.

Who is Eligible

An Eligible Employee (or "Employee") means an individual employed by the Group who works on a full-time basis and who usually works at least 30 hours a week. An Employee includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an Employee under the Group's health Benefit Plan.

An Eligible Employee does not include:

- an Employee who works on a part-time, temporary, seasonal, or substitute basis or
- an Employee who is covered under:
  - a self-insured Employee welfare Benefit Plan that provides health Benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
  - the Medicaid program if the Employee elects not to be covered;
  - another federal program, including the CHAMPUS program or Medicare program, if the Employee elects not to be covered; or
  - a Benefit Plan established in another country if the Employee elects not to be covered.

If two members of the same Family (such as husband and wife or parent and Child) both qualify as Eligible Employees of the Group, each may enroll separately as a Covered Employee. An Employee must reside, live or work in the Service Area. Dependents are not required to reside with the Subscriber.

Eligible Dependents

A Dependent means an Employee's:

- Lawful Spouse
- Child(ren)
- Domestic Partner who may be the same or opposite gender as the Eligible Employee.

See **Adding Dependents to Your Certificate of Coverage** on page 27 for additional information. **Note**: A person may not be a covered Dependent for more than one Eligible Employee.

Special Needs/Dependent Children Over 26

You or Your Spouse may have a Child(ren) with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all the terms of this section and the Certificate of Coverage, such a Child may stay eligible for Dependent health Benefits past this Certificate of Coverage's age limitation of 26 for Eligible Dependents. The Child will stay eligible as long as the Child is and remains unmarried and incapable of earning a living, and depends on You for most of his or her support and maintenance.

A disabled Dependent is eligible to enroll beyond the limiting age regardless of the date of disability if he or she has been medically certified as disabled and dependent on the parent. A Child does not have to be previously enrolled or found disabled prior to the limiting age for the Child to be considered an Eligible Dependent.

For the Child to stay eligible, You must send Us the "Request to Renew Health Coverage – Disabled Dependents" form indicating that the Child is incapacitated or developmentally disabled and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches the age limit to do this. We can

ask for periodic proof that the Child's condition continues. We will not require proof more frequently than annually after the second anniversary of the date the Child attains the limiting age. Otherwise, the Child(ren)'s coverage ends when the Child reaches age 26.

It is the responsibility of the Employee to apply for coverage for Dependents.

Enrollment

Any person who qualifies as an Eligible Employee of the Group on the day prior to the Certificate of Coverage Effective Date, or any person who has continued Group coverage with the Group under applicable federal or state law, is eligible immediately. The Enrollment Form for this Employee should be submitted with the Group Application.

Otherwise, an Eligible Employee is qualified to apply for the Plan during the Initial Enrollment Period, which is the 31 days before the first of the month following completion of the Waiting Period. The Waiting Period is a required period of continuous, full-time employment that must be completed before an Eligible Employee may apply for MHHIC coverage. The length of the Waiting Period may be one (1) or two (2) months and is selected by the Group on the Group's Application.

Exception to the Waiting Period

An exception to the Waiting Period will be made under certain circumstances for an Eligible Employee who has previously completed the Waiting Period, and then ceased to be eligible due to termination of employment. If this individual returns to an Eligible Employee status within six (6) months after the date of termination, the Employee is eligible on the first day of the month following the date of return. The Eligible Employee must apply within 31 days of the date of the return.

Special Enrollment

An Employee who is Eligible, but who has not elected to enroll during an Initial Enrollment Period or during the Annual Open Enrollment Period, may apply for enrollment within the 31 days following:

- the date he or she first acquires an Eligible Dependent, whether by marriage, adoption, placement for adoption or is a party to a suit in which the insured seeks to adopt or an eligible foster Child;
- moving outside of prior health insurance Plan's Service Area, with proof of move;
- legal separation or divorce;
- court order or decree;
- reaching maximum age 26 for Dependent coverage;
- loss of other coverage, lay-off, termination of employment, or reduction in hours;
- death of policyholder;
- loss of Medicare, Medicaid, Tricare, SCHIP, where health coverage was a Benefit; or
- return from active military service.

An Employee who gains a new Dependent due to birth must enroll the Newborn Child within 60 days after the date of birth.

Annual Open Enrollment

An Eligible Employee may apply for enrollment during the Annual Open Enrollment Period. If an Eligible Employee does not apply within the 31 days of the Initial Enrollment, Annual Open Enrollment, or Special Enrollment Periods as outlined above, he or she becomes a late enrollee.

Enrollment at Time of Employee Enrollment

If a person meets the above definition of Eligible Dependent on the date the Eligible Employee is qualified to apply for the Plan, then the Eligible Dependent qualifies to apply at the same time that the Eligible Employee applies, and should be included on the Eligible Employee's Enrollment Form.

Initial Enrollment Period for Dependent Only

An Eligible Dependent is qualified to apply for the Plan during the Initial Enrollment Period, which is the 31 days following the date he or she meets the above definition of an Eligible Dependent.

Late Enrollees

As defined, a late enrollee is an Eligible Employee or Dependent who submits his or her written Application for enrollment after the expiration of the Initial Enrollment Period, a Special Enrollment Period, or after the expiration of the Annual Open Enrollment Period. There are exceptions to this definition in which an individual who did not enroll for coverage within the Initial Enrollment Period will not be considered a late enrollee. If:

- the individual:
  - was covered under another health Benefit Plan or self-funded Employer health Benefit Plan at the time the individual was eligible to enroll;
  - declined in writing to enroll, at the time of initial eligibility, stating that coverage under another health Benefit Plan or self-funded Employer health Benefit Plan was the reason for declining enrollment;
  - has loss of coverage under another health Benefit Plan or self-funded Employer health Benefit Plan as a result of termination of employment; reduction in the number of hours of employment; termination of the other Plan's coverage; termination of contributions toward the Premium made by the Employer; or the death of a Spouse or divorce; and
  - requests enrollment within 31 days from the loss of coverage under their prior health Benefit Plan or self-funded Employer health Benefit Plan;
- the individual is employed by an Employer who offers multiple health Benefit Plans and the individual elects a different health Benefit Plan during an open enrollment period;
- a court has ordered coverage to be provided for a Spouse under a covered Employee's Plan and the request for enrollment is made within 31 days from the date the court order was issued or notification of the court order;
- a court has ordered coverage to be provided for a Child under a covered Employee's Plan and the request for enrollment to the Employer is made within 31 days from the date the court order was issued to the Employee or notification of the court order;
- the individual is a Child of a covered Employee and has lost coverage under Chapter 62, Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §1396, et seq., Grants to States for Medical Assistance Programs), other than coverage consisting solely of Benefits under Section 1928 of that Act (42 U.S.C. §1396s, Program for Distribution of Pediatric Vaccines);
- the individual has a change in Family composition due to marriage, birth of a Child, adoption of a Child, or because a Member becomes a party in a suit for the adoption of a Child;
- an individual becomes a Dependent due to marriage, birth of a Newborn Child, adoption of a Child, or because a Member becomes a party in a suit for the adoption of a Child; and
- the individual described in subparagraphs 4, 5 and 6 of this subsection requests enrollment within 31 days after the date of the marriage, adoption of the Child, loss of the Child's coverage, or within 31 days of the date a Member becomes a party in a suit for the adoption of a Child.
- the individual requests enrollment due to the birth of a Newborn Child within 60 days after the date of the Child's birth.

Special Enrollment Periods for Eligible Employees and Dependents

Eligible Employees who do not enroll themselves and/or their Eligible Dependents during the Initial Enrollment Period because they were covered by another health Benefit Plan may do so within 31 days after the other coverage terminates, if the following requirements are met:

- If the other coverage was COBRA continuation under another Plan, that continuation period must have been exhausted and have included the Eligible Employee, Dependent Spouse and Dependent Children before the Eligible Employee may enroll themselves and/or other affected persons under this Plan.
- If the other coverage was not COBRA continuation, then any Employer contribution toward the cost of coverage must have been terminated or that coverage must have been terminated because of a loss of eligibility by the person through whom coverage was obtained. Loss of eligibility for coverage includes loss of coverage as a result of:
  - divorce;
  - death;
  - termination of employment or reduction in hours of employment;
  - loss of Dependent status;
  - loss of eligibility for PPO or other Group coverage as a result of ceasing to meet Service Area requirements;

- Employer contributions toward that coverage have been terminated;
- exhaustion of COBRA or State Continuation; or
- exceeded lifetime limit on medical Benefits.

In addition, the Eligible Employee must have declined enrollment for Employee and/or Dependent coverage during the Initial Enrollment Period by means of a written statement indicating that the reason for declining enrollment was other coverage. However, a written statement may be required only if the consequences of failing to provide such a statement were explained to the Employee at the time of Initial Enrollment.

An Eligible Employee who did not enroll during the Initial Enrollment Period may enroll for Employee and/or Dependent coverage within 31 days after he or she marries or acquires a Dependent Child or Children by adoption, or when the Employee is a party in a suit to adopt a Child. In the event that the Employee acquires a new Dependent Child by birth, the Employee may enroll for coverage within 60 days after the date of birth.

An Eligible Employee who did not enroll his or her Spouse during an Initial Enrollment Period may enroll that Spouse within 31 days after the Eligible Employee acquires a Dependent Child or Children by adoption or when the Employee is a party in a suit to adopt a Child. If the Eligible Employee does not apply to enroll an Eligible Dependent within 31 days of when he or she qualifies as an Eligible Dependent, such Dependent becomes a late enrollee. An Eligible Dependent whose coverage was canceled by request while still entitled to coverage is also considered a late enrollee if requesting to be covered again.

An Eligible Employee who did not enroll during an Initial Enrollment Period may enroll within 60 days after coverage under a Medicaid plan is terminated as a result of loss of eligibility for such coverage. An Eligible Dependent whose state assistance (Medicaid or SCHIP) is terminated due to loss of eligibility may enroll within 60 days after the state coverage is terminated as a result of loss of eligibility for such coverage.

An Eligible Employee or Eligible Dependent who did not enroll during an Initial Enrollment Period may enroll within 60 days after becoming eligible for Medicaid or SCHIP Premium assistance subsidy (including coverage under any waiver or demonstration project conducted under or in relation to such a state Plan).

Special Enrollment of an Eligible Dependent Spouse

A Spouse who is an Eligible Dependent but did not enroll in the Plan either at the time the Eligible Employee enrolled or during the Initial Enrollment Period may enroll within 31 days following the date a Dependent Child becomes newly eligible whether through birth, adoption, placement for adoption, or is a party to a suit in which the Eligible Employee seeks to adopt.

If the Eligible Employee does not apply to enroll an Eligible Dependent within 31 days (60 days for the birth of a Newborn Child) of when he or she qualifies as above, he or she becomes a late enrollee. An Eligible Dependent who was canceled by request while still entitled to coverage is also considered a late enrollee if requesting to be covered again.

Coverage Start

Coverage for an Eligible Employee and his or her Eligible Dependents is effective once We receive an accurate and complete Application, and the Group pays Us the required Premium. Coverage under the Plan becomes effective:

- for any person who qualifies as an Eligible Employee on the day prior to the Effective Date of the Certificate of Coverage and his or her Eligible Dependents, or any person who has continued Group coverage under applicable federal or state law, on the Effective Date of the Certificate of Coverage;
- for Eligible Employees and their Eligible Dependents who apply during their Initial Enrollment Period, on the first day of the month following the end of the Waiting Period;
- for an Eligible Employee or Eligible Dependent who applies during a Special Enrollment Period, on the first day of the month following the date of the Qualifying Life Event;
- for an Eligible Employee or Eligible Dependent who submits an Enrollment Form during the Annual Open Enrollment Period, on the first day of the month following the Annual Open Enrollment period.

Adding Dependents to Your Certificate of Coverage

For a person who becomes an Eligible Dependent after the date the Eligible Employee's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:

- *Newborn Children*
  A Member or a Dependent’s Newborn Child(ren) is eligible for coverage. MHHIC must be notified within 60 days of birth to add the Newborn as a covered Dependent and continue coverage beyond the first 61 days after the Newborn’s birth. An additional Premium will apply.

- *Adopted Children*
  A Member’s adopted Child(ren) is eligible for coverage, including a Child placed for adoption or a Child for whom the Member or his or her legal Spouse is a party to a suit to adopt. MHHIC must be notified within 31 days of adoption, or placement for adoption, or the date the Member or Member’s legal Spouse becomes a party to a suit to adopt the Child to add as a covered Dependent. An additional Premium will apply.

- *Court Ordered Dependent*
  If a court has ordered a Subscriber to provide coverage for an Eligible Dependent (including Spouse) Eligible Dependent(s) will be eligible for coverage. MHHIC must be notified within 31 days of court order to add the Eligible Dependent(s) as a covered Dependent. An additional Premium will apply.

- *Grandchildren*
  An Enrollment Form and Premium payment must be received within 31 days of the date the grandchild first qualifies as an Eligible Dependent. Coverage will become effective on the first day of the month following the date the Application for coverage is received.

- *Other Dependents*
  An Enrollment Form must be received within 31 days of the date that a person first qualifies as an eligible Family member or Dependent. Coverage will become effective on the first day of the month following the date the Enrollment Form is received, approved and any required Premium is paid.

In no event will an Eligible Dependent’s coverage become effective prior to the Eligible Employee's Effective Date of coverage.

Coverage for late enrollees who apply outside of the Group’s Annual Open Enrollment Period will be effective on the first day of the month of the next Annual Open Enrollment Period provided that the late enrollee is an Eligible Employee or an Eligible Dependent on that date and further provided that he or she applies or re-applies during that Annual Open Enrollment Period.

Notification of Eligibility Change

Any person who does not satisfy the eligibility requirements is not covered by the Plan and has no right to any of the Benefits provided under the Plan. The Group and/or the covered Employee must notify MHHIC within 31 days of any change that affects an individual's eligibility under the Plan, including whether a covered Dependent meets the Eligible Dependent criteria set forth under the topic **Who Is Eligible** in this chapter of the Certificate of Coverage.

Change to Group Certificate of Coverage

We may modify the Group Certificate of Coverage on any Anniversary Date provided: the modification is uniform among all Large Employers, as applicable, covered by the Group Certificate of Coverage; and We notify the Commissioner of Insurance and each affected Group no later than the 60th day before the date such modification is effective.

Termination of Coverage

Employee & Dependents

Your coverage ends without notice from Us on the earliest of:

- the last day of the month after the date You no longer meet the definition of an Eligible Employee; however, coverage will remain in force until the end of the month in which the Group notifies Us that the Member is no longer eligible. The Group will be liable to Us for any Premium, including Premium for Dependent coverage, for the period of coverage until the end of the month in which the Group provides Us such notice;

- the last day of the month in which You exceed the maximum number of months of paid personal or Medical Leave of Absence (MLOA) for which Your Employer provides continuing eligibility for coverage under this Plan;
- the end of the last period for which Premium payment has been made to Us, subject to the Grace Period; or
- in the event of fraud or intentional misrepresentation of material fact by You or Your covered Dependent, except as described under the **Incontestability** provision, or fraud in the use of services or facilities, thirty (30) days after written notice from MHHIC.

Covered Dependent coverage will also end the date Your coverage terminates.

Group Policy

The coverage of all Members shall terminate if the Group Policy is terminated. If We terminate the Group Policy, We will notify the Group of cancellation. In addition, the Group Policy and any associated Certificate of Coverage may be terminated by the Group on any renewal date. In either situation, it is the Group's responsibility to notify all covered Employees. The Policy or this Certificate of Coverage may be terminated by Us:

- for non-payment of required Premium (after the expiration of the 30-day Grace Period);
- on the date of fraud or intentional misrepresentation of a material fact by the Group, after not less than 30 days' written notice, except as indicated in the **Time Limit on Certain Defenses** provision;
- for any of the following reasons. We must give the Group written notice of cancellation at least 30 days in advance if termination is due to:
  - failure to maintain the required Group size or required minimum participation or contribution levels for a period of at least six (6) consecutive months at which time the coverage will terminate at the renewal following the six (6) consecutive months;
  - relocation of all of the Group's Eligible Employees to reside or work in a location outside of the Service Area;
  - relocation of the Group's primary business location to a location outside the Service Area, unless the majority of the Group's Eligible Employees remain in Texas; or
  - Subscribers no longer residing, living, or working in the Service Area, or area for which MHHIC is Authorized to do business, provided coverage is terminated uniformly without regard to the health status of an enrollee.
- on any renewal date if We discontinue this Large Employer Group health Benefit Plan, We must give the Group and the Commissioner of Insurance written notice of cancellation at least 90 days prior to the discontinuation and again at least 30 days in advance of the date on which discontinuation of coverage is effective and make available to the Large Employer Group, all Plans that we make available to new Large Employer Group business in the state
- on any renewal date if We are also canceling all Large Employer Group health Benefit Plans in the state or in a geographic Service Area. We must give the Group and the Commissioner of Insurance written notice of cancellation at least 180 days in advance and again at least 30 days in advance of the date on which termination of coverage is effective.

This Certificate of Coverage is a part of the Group Policy as if fully incorporated therein and any direct conflict between the Group Policy and the Certificate of Coverage will be resolved according to the terms which are most favorable to the Member.

State Continuation Provisions

If Your coverage terminates, You will have the right to continue under the Group Certificate of Coverage as outlined below. The Group is responsible to provide You with information on Your options. No evidence of insurability is required. In order to be eligible for this option You must have been continuously covered under the Certificate of Coverage for at least three (3) consecutive months prior to termination and coverage must have terminated for any reason other than involuntary termination for cause. Involuntary termination for cause does not include termination for any health-related cause.

Your written Application and payment of the first Premium must be received by the Employer within 60 days after the later of the date the Group coverage would otherwise terminate or the date that either We or the Employer gives You notice of Your right to continue coverage. Payment of the Premium must be received not later than 45 days after the date of the initial Application.

There is no right of continuation if:

- the termination of coverage occurred because You failed to pay any required Premium; or
- the Group coverage terminates in its entirety.

Continuation of Coverage

For Members

If You choose to continue coverage under the Group Certificate of Coverage, continuation will be permitted for the applicable period shown below. The Premium rate will not exceed 102% of the Group Premium. You must make the payment no later than the 45th day after the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other Premium shall be considered timely if made by the 30th day after the date on which payment is due. The Premium will be payable in advance to the Group on a monthly basis. Continuation will not terminate until the earliest of:

- for any Member not eligible for continuation coverage under Title X, Consolidated Omnibus Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), nine months after the date the Member elects to continue the coverage;
- for a Member eligible for continuation coverage under COBRA, six (6) additional months following any period of continuation coverage provided under COBRA;
- the date You fail to make timely Premium payments;
- the date on which You are covered under Medicare;
- the date on which You are covered for similar Benefits under another Group or individual Policy;
- the date on which an enrollee is covered for similar services and Benefits by any other Plan or program; or
- the date the Group coverage terminates in its entirety.

Additional Continuation Rights for Certain Covered Dependents

If coverage terminates as the result of Your death, retirement, or divorce, a covered Dependent's coverage can continue. A Dependent who qualifies for this will have the right to continue under the Group Certificate of Coverage as outlined below. No evidence of insurability is required. In order to be eligible the covered Dependent must have been covered under the Plan for at least one (1) Year, unless the covered Dependent is an infant under one (1) year of age. There is no right of continuation if:

- continuation is required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please check with Your Employer.
- coverage terminates due to any of these circumstances:
  - the covered Dependent fails to make timely Premium payments; or
  - the covered Dependent becomes eligible for substantially similar coverage under another Plan or program, including a Group health insurance Policy or Contract, Hospital or medical service Subscriber Contract, or medical practice or other prepayment plan.

If the covered Dependent chooses to continue coverage under the Group Certificate of Coverage, continuation will be permitted for a maximum of three (3) years. The Premium will be payable in advance to the Group on a monthly basis. Continuation will not terminate until the earliest of the following dates:

- three (3) years after the date coverage would have terminated because of the Employee's death, retirement, or divorce; or
- the date the covered Dependent fails to make timely Premium payments.

COBRA Continuation

Most Employers who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the Group is subject to the federal law which governs this provision, Members may also be entitled to a period of continuation of coverage under this Act prior to State Continuation coverage. Check with the Group for details. COBRA coverage is available to You and/or Your Eligible Dependents under the following circumstances:

- if You terminate or are terminated from Your employment for reasons other than gross misconduct, or if Your hours are reduced, You and Your covered Dependents can continue coverage for up to 18 months;
- if the Social Security Administration determines that You or any of Your Eligible Dependents were disabled when You lost Your job or were disabled within 60 days after the job loss, You and Your Eligible Dependents may be eligible for 29 months of continuation;

- if You have Family coverage, and Your Eligible Dependents lose coverage because either 1) You expire or are divorced, or 2) You become eligible for Medicare, Your Eligible Dependents may continue coverage up to 36 months;
- a Child who is no longer an Eligible Dependent may also continue coverage up to 36 months,
- covered retirees and widows of retirees may have longer continuation rights if a Group files a Chapter 11 bankruptcy petition; and/or
- You must tell the Group if You divorce, or if Your Dependent Child is ineligible within 60 days of the date it happens. The person losing coverage will then be notified of the right to buy continued coverage. He or she will then have 60 days to elect the coverage and pay the required Premium, and another 45 days to pay the Premium covering the time period before election.

If the terminated Member is a minor, his or her parent or guardian may act on his or her behalf to elect COBRA continuation coverage.

Second Qualifying Life Event

If Your Family has another Qualifying Life Event (such as a legal separation, divorce, etc.) during their initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), Your Spouse and Dependent Children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original Qualifying Life Event. Such additional coverage is only available if the second Qualifying Life Event would have caused Your Spouse or Dependent Children to lose coverage under the Plan had the first Qualifying Life Event not occurred. A Qualified Beneficiary must give timely notice to the Plan administrator in such a situation.

Continuation of Coverage During a Military Leave

Another federal law, the Uniformed Service Employment and Reemployment Rights Act (USERRA) requires that Employers provide Employees who are members of the military with military leave during the course of their employment. Employers must provide a cumulative total of five (5) years, and in certain circumstances, more than five (5) years of military leave.

Extension of Benefits

If a Member is totally disabled on the date of termination of the Certificate of Coverage, coverage will be extended. Benefits will continue to be paid under the terms of the Certificate of Coverage for Eligible Expenses due to the disabling condition. Extension of Benefits will continue until the earlier of:

- the date payment of the maximum Benefit occurs;
- the date the Member ceases to be totally disabled; or
- the end of 90 days following the date of termination.

This Extension of Benefits is not applicable if the Certificate of Coverage is replaced by another carrier providing substantially equivalent or greater Benefits.

Notification Requirements

The covered Dependent must notify the Group within 15 days of the covered Employee's death, retirement, or divorce. The Group will immediately provide written notice to the covered Dependent of the right to continue coverage and will send the election form and instructions for Premium payment.

Within 60 days of the covered Employee's death, retirement, or divorce, the covered Dependent must give written notice to the Group of the desire to exercise the right of continuation, or the option expires. Coverage remains in effect during the 60-day period provided Premium is paid.

HOW YOUR CERTIFICATE OF COVERAGE WORKS

ALTHOUGH HEALTHCARE SERVICES MAY BE, OR HAVE BEEN, PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK, USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE, OR HAVE BEEN, PROVIDED AT, OR THROUGH, THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN. HOWEVER, THERE ARE CERTAIN OUT-OF-NETWORK SERVICES (EMERGENCY CARE, SERVICES PROVIDED IN AN IN-NETWORK FACILITY AND DIAGNOSTIC IMAGING OR LABORATORY SERVICE PERFORMED IN CONNECTION WITH AN IN-NETWORK SERVICE, WHERE BALANCE BILLING BY THE PROVIDER IS PROHIBITED. IN THESE SITUATIONS, YOUR FINANCIAL RESPONSIBILITY IS LIMITED TO THE APPLICABLE COPAYMENT, COINSURANCE, AND DEDUCTIBLE BASED ON THE PLAN'S INITIAL ALLOWED AMOUNT.

The Plan pays a portion of Covered Expenses after Members meet the applicable Copayments and Deductibles each Year. This chapter describes Deductibles and Copayments and discusses steps Members should take to ensure that You receive the highest level of Inpatient and Outpatient Benefits available under this Plan. See the **DEFINED TERMS** chapter of this Certificate of Coverage for a definition of Covered Expenses and Covered Services.

The Inpatient and Outpatient Benefits described in the following sections are provided for Covered Expenses incurred by Members while covered under this Plan. An expense is incurred on the date You receive the service or supply for which the charge is made. These Benefits are subject to all provisions of this Plan that will comply with coverage standards as required by law This may limit Benefits or result in Benefits not being payable. Either the Member or the Provider of service must Claim Benefits by sending MHHIC properly completed Claim forms itemizing the services or supplies received and the charges.

This section shows the maximum Covered Expense for each type of Provider. No Benefits are payable unless the Member's coverage is in force at the time services are rendered, and the payment of Benefits is subject to all the terms, conditions, Limitations, and Exclusions of this Plan.

New Plan Members

Continuity of Care

Requests for continuity of care for new enrollees must be made within 90 days of the Effective Date. See *Physician or Provider Termination/Continuity of Care/Special Circumstances* on page 32 for more information.

Service Providers

Physician or Provider Termination/Continuity of Care/Special Circumstances

A "**Special Circumstance**," for purposes of this provision, is a condition regarding which the treating Physician or Provider believes that discontinuing care by that Physician or Provider could cause harm to You or Your covered Dependent who is a patient. Special circumstance may include a disability, Acute condition, Life-Threatening Illness, or pregnancy. The treating Physician or Provider may request continuity of care by completing the Continuity of Care form found here:
https://healthplan.memorialhermann.org/-/media/memorial-hermann/healthplan/files/members/health-plan-commercial-continuity-of-care-form.ashx.

In the event of a special circumstance, continuity of care for anticipated out-of-network services will be allowed when:

- a Member is pregnant,
- a Member has a condition in which Provider continuity may prevent a recurrence or worsening of the conditions under treatment as indicated by one (1) or more of the following:
    - Acute exacerbation of a Chronic disease (e.g., asthma)
    - Post-operative or other post-service treatment (e.g., follow-up Emergency care visit)
    - Previous staged surgical procedures (e.g., cleft palate repair)
    - Ongoing oncology treatment (e.g., to complete current chemotherapy cycle)
    - Other requests will be considered by the Medical Director with appropriate clinical information.

Members may continue care for a specified transitional period following the effective date of the Provider's termination, as follows:

- Members who are pregnant may continue care through the postpartum period, ending with the 6-week checkup following childbirth.
- Members who have a terminal illness may continue care for a period of nine (9) months.
- Members with a disability, Acute condition, or Life-Threatening condition may continue care for a period of 90 days.

A continuing care patient means an individual who:

- Is undergoing a Course of Treatment for a serious and complex condition from the Provider or facility;
- Is undergoing a course of institutional or Inpatient care from the Provider or facility;
- Is scheduled to undergo non-elective Surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a Surgery;
- Is pregnant and undergoing a Course of Treatment for the pregnancy from the Provider or facility; or
- Is or was determined to be terminally ill and is receiving treatment for such Illness from such Provider or facility.

If You or Your covered Dependent has a "special circumstance", We will continue to provide coverage at Our usual Contract rate for that terminated Physician or Provider, unless the termination was for reason of medical competence or professional behavior. The Member may elect to continue treatment under the same terms and conditions that would apply, had the termination not occurred. MHCHP is not obligated to reimburse a terminated Physician or Provider or, if applicable, the Contract holder, at the Network Provider level of coverage for ongoing treatment beyond the specified transitional periods outlined above.

All continuity of care requests will be referred to Case Management for transition to Network Providers.

Out-of-Network Providers Special Circumstances Access

Covered Expenses for the services of a Out-of-Network Provider will be paid according to the in-network Benefit schedule only:

- when the services are not available through Network Providers.

Additionally, the federal No Surprises Act (NSA) and Texas Senate Bill 1264 prohibits Balance Billing by Providers for certain out-of-network services: Emergency care, services provided by Facility-Based Providers in an in-network facility, and diagnostic imaging or laboratory services performed in connection with an in-network service. For applicable Claims, We will provide a prompt reimbursement at the Usual and Customary Rate or at an agreed rate. Your financial responsibility is limited to the applicable Copayment, Coinsurance, and Deductible based on the Plan's initial Allowed Amount.

If a Medically Necessary Covered Service is not available through a Network Physician or Provider, We may Authorize care from an Out-of-Network Provider, including one outside the Service Area. We will process the Authorization to see a requested Out-of-Network Provider within five (5) business days after receipt of reasonably requested documentation from You or Your Network Provider. If We approve the Authorization and determine the approved Provider has expertise in the necessary specialty, is reasonably available to You considering Your medical condition and location, and that You will not be Balance Billed (the Authorization criteria), then, upon Your request, We will recommend at least one additional Out-of-Network Provider that meets the same criteria. If the Out-of-Network Provider We approve does not meet the Authorization criteria, We will explain why and explain Your right to request Our recommendation of Out-of-Network Providers who meet the required criteria. Upon your request, We will recommend at least two Out-of-Network Providers who meet the required criteria. The Out-of-Network Provider will be reimbursed at the Usual and Customary Rate or an agreed upon rate. You are responsible for any Cost Sharing that applies to the Covered Service at the in-network Benefits level.
If You choose to receive the Medically Necessary Covered Service from an Out-of-Network Provider that is not recommended or approved by Us, You will be responsible for any Balance Bill such Out-of-Network Provider may charge in addition to the Usual and Customary Rate or agreed rate We will pay the Provider.

If You receive a Balance Bill from an approved Out-of-Network Provider, please contact Customer Service at 855-645-8448. You may also contact the Texas Department of Insurance's Consumer Information Help Line at 800-252-3439.

Out-of-Network Providers/Emergency Care

Please notify Us as soon as possible after obtaining Emergency care or services outside Your Provider Network. In most situations, out-of-network services must receive Preauthorization in order to be covered at the "in-network" level of payment. We may approve or deny coverage of post stabilization care within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one (1) hour from the time of the request. If You require Hospitalization in an Out-of-Network Hospital facility as a result of the emergent condition, We may also require that You transfer to a contracted or Network Hospital Provider after it has been determined by the treating Physician that Your medical Emergency has been Stabilized.

The Out-of-Network Provider must notify Us of an Inpatient Admission, and submit their request for concurrent Inpatient services within 48 hours of Admission. If we determine Your Inpatient services, including Observation care, are not Medically Necessary, We may determine the services are not Covered Expenses under this Certificate of Coverage. Your Provider may obtain Preauthorization when it is required for continued services by calling Us. For more information on what services may require Preauthorization, please refer to the **SCHEDULE OF BENEFITS**.

Specialists and Other Providers

A Specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of Specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

The Network Providers listed in the Provider directory have agreed to provide You with Your health care coverage. Services may be provided by a Network Provider or Out-of-Network Provider without a Referral; however, some services may require Preauthorization.

If You have been going to one Network Provider, You are not required to continue going to that same Provider.

Treatment Received from Foreign Country Providers

Benefits for services and supplies received from Foreign Country Providers are covered for medical Emergencies where treatment could not have been delayed until the Member was able to return to the United States. We do not accept assignment of Benefits from Foreign Country Providers. You can file a Claim with Us for services and supplies from a Foreign Country Provider, but any payment will be sent to You. You are responsible for paying the Foreign Country Provider. You are also responsible at Your expense for obtaining an English language translation of Foreign Country Provider Claims and any medical records that may be required.

Benefits are subject to all terms, conditions, Limitations, and Exclusions of this Certificate of Coverage and will not be more than would be paid if the service or supply had been received in the MHHIC Service Area.

Network Hospitals, Physicians, and Other Network Providers

Covered Expenses for Network Providers are based on Our Negotiated Rate. Network Providers have agreed NOT to charge You and MHHIC more than the MHHIC Negotiated Rates. In addition, Network Providers will file Claims with Us for You. A directory of local MHHIC Network Providers is available through Our website at https://healthplan.memorialhermann.org/find-a-doctor?network=Select+PPO or call Customer Service at 855-645-8448 for assistance in finding Network Providers near You. The online Provider directory is Your best source for a current up-to-date Provider list.

We will provide written notice to You within a reasonable period of time of any Network Provider's termination or breach of, or inability to perform under, any Provider Contract, if We determine that a Member may be materially and adversely affected, and provide You with a current list of Network Providers.

The Plan will provide reimbursement to a Network Pharmacist for the provision of a Covered Service that is within the scope of the pharmacist's license when the same service is covered if provided by a Physician, Advanced Practice Nurse (APN), or a Physician Assistant (PA).

Important Notice

Benefit coverage may be impacted when legislative changes occur. State and/or federal legislative law changes may involve the creation of new laws, the repeal of old laws, or amendments to existing legislation to address emerging issues or correct outdated provisions. Your Certificate of Coverage and/or Schedule of Benefits will be updated annually to reflect legislative changes which will be effective upon Plan renewal unless otherwise required by legislation.

Texas Department of Insurance Notice of Rights

Your rights with a preferred provider benefit plan (PPO)

Your plan

- Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your plan's network

- Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

  If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

Health care costs

- You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

List of doctors

- You can get a directory of health care providers that are in your plan's network. You can get the directory online at https://healthplan.memorialhermann.org/members/ or by calling 855-645-8448. If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Health care bills

- If you want to see a doctor or facility that isn't in your plan's network, you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.

  If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

Emergency Care/Mental Illness Emergency Care

Coverage for Emergency, mental Illness related Emergencies, and Urgent Care includes coverage of trauma services originated in a Hospital Emergency facility, freestanding Emergency Medical Care facility, comparable Emergency facility, or mental health facility that can provide 24-hour residential and psychiatric services and that is:

- a facility operated by the Texas Department of State Health Services;
- a private mental Hospital licensed by the Texas Department of State Health Services;
- a community center as defined by Texas Health and Safety Code §534.001;
- a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;
- an identifiable part of a general Hospital in which diagnosis, treatment, and care for persons with mental Illness is provided and that is licensed by the Texas Department of State Health Services; or
- a Hospital operated by a federal agency, as Medically Necessary and appropriate, to be continued at least until, in the judgment of the attending Physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another facility.

We also provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, to be performed by the Hospital in accordance with federal law requirements, but only as necessary to determine whether an Emergency Medical Condition exists.

Covered Expenses will be paid for initial care for a Medical Emergency/Mental Illness related Emergency. You will be held harmless for any amounts beyond Copayments, Deductibles or other Out-of-Pocket Expenses You would have paid using a Network Provider.

If You have a Medical Emergency or mental Illness related Emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest Emergency room or Hospital. Call for an Ambulance if You need it. You do not need to get approval or Authorization first from Us.
- As soon as possible, make sure that We have been told about Your Emergency. We need to follow up on Your Emergency care. You or Your authorized designee or healthcare Provider should call to tell Us about Your Emergency care, usually within 48 hours. Please notify Us when You have a Medical Emergency by calling Our Customer Service Department at the telephone number listed on the back of Your Member ID card. Your healthcare Provider may notify MHHIC Medical Management at 855-645-8448.

Medical Emergencies and Ambulance Services (in which getting to the Emergency room in any other way could endanger Your health) are covered at all times, anywhere in the United States or its territories. MHHIC also covers any medical screening examination or other evaluation in a Hospital Emergency facility or comparable facility required by state or federal law that is necessary to determine whether an Emergency Medical Condition exists. For more information, see the **SCHEDULE OF BENEFITS** and **COMPREHENSIVE MEDICAL BENEFITS AND SERVICES** chapters of this Certificate of Coverage.

If You have an Emergency, the doctors who are giving You Emergency care will decide when Your condition is stable, and the Medical Emergency is over. After the Emergency is over, You are entitled to follow-up care to ensure Your condition continues to be stable. Your follow-up care will be covered by Us.

If Emergency care is provided by Out-of-Network Providers, please contact Us for help coordinating follow-up care with a Network Provider as soon as Your medical condition and the circumstances allow. After Your Emergency, follow-up care outside the Network area is covered upon Preauthorization from Us. Approval or denial of coverage of post-stabilization care as requested by a treating Physician or Provider will be within the time appropriate to the circumstances relating to the delivery of the services and Your condition, but not to exceed one (1) hour from the time of the request. Continued care without Preauthorization from Us will not be covered, even if the initial onset of Your condition was of an urgent or Emergency basis.

Federal and State Balance Billing Protections:

The No Surprises Act (NSA) and Texas law established legal protections against surprise medical bills. Surprise medical bills (or "Balance Bills") can arise when a Member inadvertently or due to an Emergency receives care from an Out-of-Network Hospital, Physician, or other Out-of-Network Providers they did not choose. Doctors and Hospitals are not allowed to bill patients more than the in-network Cost Sharing amount for these Covered Services.

The federal No Surprises Act and Texas laws prohibit Balance Billing for the following Medically Necessary Covered Services:

- Air Ambulance;
- Emergency ground Ambulance;
- Emergency care; and
- Care received by Out-of-Network Facility-Based Providers at in-network facilities when the patient did not have a choice in Providers.

A Facility-Based Provider or other health care practitioner may not be included in MHHIC's Provider network. When MHHIC receives a Claim for any of the above services from an Out-of-Network Provider, it will advise the Provider of the applicable in-network Cost Sharing amount for the services. MHHIC will send payment to the Provider and will send the Member an Explanation of Benefits (EOB) showing how the Claim was processed and indicating the in-network Cost Sharing amount the Member owes to the Provider. It is at this point that the Out-of-Network Provider is allowed to send the Member a bill for no more than the in-network Cost Sharing amount. Unless the Member elects to receive out-of-network care and signs a waiver of Balance Billing protections, an Out-of-Network Facility-Based Provider or other health care practitioner may not Balance Bill the Member for amounts not paid by MHHIC for Covered Services or supplies provided in an in-network facility. If the Member receives a Balance Bill, the Member should contact MHHIC.

The NSA gives consumers the right to Appeal health Plan decisions to incorrectly deny or apply out-of-network Cost Sharing to surprise medical bills, first to the health Plan, and then, if the Plan upholds its decision, to an independent external reviewer.

For information about federal protections against surprise medical bills, or to submit a Complaint involving an air Ambulance claim, You may refer to: https://www.cms.gov/nosurprises/consumers.

For more help:

- Call the No Surprises Help Desk at 1-800-985-3059 (available 8 a.m. to 8 p.m. EST, 7 days a week).
- Get help in a language other than English. Information about how to access these services is available through the No Surprises Help Desk.
- Call the No Surprises Help Desk to get this information in a format other than standard print, at no cost to You.

For concerns related to Balance Bills You receive for other out-of-network services listed in this section, please contact Customer Service at 855-645-8448. You may also contact the Texas Department of Insurance at 800-252-3439 or via email at ConsumerProtection@tdi.texas.gov.

Paying for Services

Deductibles

If applicable, Deductibles are annually set amounts of Covered Expenses Members must pay before We will pay for any Benefits for such charges. The Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person can be used to meet the Deductible. The Deductible amount is shown in the **SCHEDULE OF BENEFITS**.

Once the Deductible is met, MHHIC will pay Benefits for other Covered Charges above the Member's reached Deductible amount. The Deductible does not include any Coinsurance or Copayments applicable for the rest of the Certificate of Coverage Year. All charges must be incurred while the Member(s) are covered under this Certificate of Coverage.

Family Deductibles

If applicable, The Family Deductible is a cumulative amount all Family members enrolled in the same Certificate of Coverage meet for each Certificate of Coverage Year. Although Family members incur Covered Charges independently based on the individual Deductible amount, each paid expense contributes to the cumulative Family Deductible limit.

The Family Deductible limit can be met by a combination of Family members with no single individual within the Family contributing more than the individual Deductible limit amount in a Certificate of Coverage Year. Once this Family Deductible limit is satisfied for that Year, We provide coverage for all Covered Charges for all Members who are part of the covered Family, less any applicable Coinsurance or Copayment, for the rest of the Calendar Year.

Prescription Drug Deductibles

If applicable, the Prescription Drug Deductible is the amount of Covered Expenses for Prescription Drugs You must pay for each Member before any Prescription Drug Benefits are available. Only Covered Expenses are applied to a Deductible. Any expenses You incur in addition to Covered Expenses are never applied to a Deductible. Deductibles will be credited on Our files in the order in which Your Claims are processed, not necessarily in the order in which You receive the service or supply. If You submit a Claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward the applicable Deductible.

Copayments

A Copayment is a specified dollar amount a Member must pay for specified Covered Charges which are usually collected at the time of service (e.g., at Your Physician visit). Your Certificate of Coverage may be subject to a Deductible and Copayment per Inpatient Admission to any Network or Out-of-Network Hospital. If indicated on the **SCHEDULE OF BENEFITS**, this Admission Deductible is separate from any other Certificate of Coverage Deductible, and does not count toward satisfying the applicable Deductible. For any Covered Services for which both a Copayment and Deductible apply, the Copayment will apply before the Deductible.

As a courtesy to our Members, services requiring individual Member Copays - rendered by the same Physician, organization, or institution on the same day, and billed by the same tax entity - are subject to Single-Highest Copay. Single-Highest Copay refers to Member responsibilities being limited to the sole greatest Copay dollar amount for services rendered in the scenario above (e.g., a Specialist Office Visit Copay of $50 would be waived if the same Specialist performs an x-ray service with a $100 Copay on the same day as the Office Visit.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Once any applicable Deductible, Copayment, or the Prescription Drug Deductible, are satisfied, Network Providers will be paid at the Coinsurance percentage as shown on the **SCHEDULE OF BENEFITS**. We will waive the Coinsurance requirement once the Out-of-Pocket Maximum has been reached. This Certificate of Coverage's Coinsurance, as shown below, does not include Deductibles, Copayments, penalties incurred under this Certificate of Coverage's Utilization Review provisions, or any other Non-Covered Charge.

Out-of-Pocket Maximums

The Out-of-Pocket Maximum is the Cost Sharing amount of Copayment each Member, Dependents if covered by the Subscriber, and a Family, will incur for Covered Expenses in a Year. The Out-of-Pocket Maximum includes any applicable Deductibles, Copayments, and the Prescription Drug Deductible, if any, but it does not include any amounts in excess of Covered Expenses, or amounts in excess of other Benefit limits of this Plan. The Out-of-Pocket Maximum also does not include any Utilization Review penalties, brand cost differentials, or Non-Covered Charges.

When You have met Your Out-of-Pocket Maximum for a Certificate of Coverage Year as noted in the **SCHEDULE OF BENEFITS**, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of the Certificate of Coverage Year. If other than individual coverage applies, when members of the same Family covered under this Certificate of Coverage have collectively met the Family Out-of-Pocket Maximum for an Certificate of Coverage Year as noted in the **SCHEDULE OF BENEFITS**, We will provide coverage for 100% of the Allowed Amount for the rest of the Certificate of Coverage Year.

Please note that Deductible, Copayment, and Coinsurance charges accrue to meet Your Out-of-Pocket amount. However, the following do not accrue to the Out-of-Pocket amount:

- any charges in excess of the Allowable Charge;
- any penalties the Member or Provider must pay;
- brand cost differentials; and
- charges for Non-Covered Services.

Emergency Room Visits

If shown on the **SCHEDULE OF BENEFITS**, an Emergency room visit, which does not result in an Inpatient Admission immediately following the Emergency room visit, is subject to the Emergency room visit Copayment, if any, in addition to any other applicable Copayment or Deductible and does not count toward satisfying the applicable Deductible.

COMPREHENSIVE MEDICAL BENEFITS AND SERVICES

This chapter lists the types of Benefits and services We will consider as Covered Charges.

Before this Plan pays for any Benefits, a Member must satisfy any applicable Deductible or Copayment. After the applicable Deductible or Copayment has been satisfied, We will begin paying for Covered Services as described. What We will pay is subject to all the terms of this Certificate of Coverage.

The Benefits described in this chapter will be paid for Covered Expenses incurred on the date a Member received the service or supply for which the charge is made. These Benefits are subject to all terms, conditions, Exclusions, and Limitations of this Plan. All services are paid at the percentages indicated and subject to limits outlined in the chapter titled **HOW YOUR CERTIFICATE OF COVERAGE WORKS**.

Any Benefits listed in this Certificate of Coverage, which are not mandated by state or federal law may be deleted or revised. Any change will be made effective uniformly and will only occur at the time of renewal. We will notify You and the Commissioner of Insurance no later than the 60th day before the date the change is effective.

Professional Services

Covered Services rendered by a licensed Network Provider or other in-network health care practitioner and billed as an Office Visit charge, such as:

- Primary Care Provider Office Visits;
- Specialist Office Visits, including mental health Providers;
- Home Health visits; and
- Telehealth visits

Please refer to Your **SCHEDULE OF BENEFITS** for Cost Sharing requirements and other important information.

Ambulance and Pre-Hospital Emergency Benefits

Pre-Hospital Emergency Medical Services means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. We cover pre-hospital Emergency Medical Services for the treatment of an Emergency condition, when such services are provided by an Ambulance Service licensed under the State of Texas Department of State Health Services.

The following Ambulance Services are eligible for this Benefit:

- base charge, mileage, and non-reusable supplies of a licensed Ambulance company for ground or air service for transportation to and from a Hospital or Skilled Nursing Facility.
- monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with Ambulance Service. An appropriate licensed person must render the services.

We do not cover travel or transportation expenses unless connected to an Emergency Condition or due to a facility transfer approved by Us, even if prescribed by a Physician. We also do not cover non-Ambulance transportation such as van or taxicab.

Hospital/Inpatient Benefits

All Admissions including, but not limited to, elective or non-Emergency care, but excluding pregnancy, must be Authorized as outlined in the **UTILIZATION REVIEW PROCEDURE AND REVIEW PROGRAMS** chapter of this Certificate of Coverage. In addition, at regular intervals during the Inpatient stay, We will perform a concurrent review to determine the appropriateness of continued Hospitalization as well as the level of care.

Please refer to the **SCHEDULE OF BENEFITS** for Cost Sharing requirements, day or visit limits, and any Preauthorization requirements that may apply to these Benefits. Pre-Hospital Emergency Medical Services and Ambulance Services for the treatment of an Emergency condition do not require Preauthorization. The following services furnished to You by a Hospital are eligible for coverage: Inpatient Hospital services, including room and board, general nursing care, meals and special diets when Medically Necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory and other diagnostic tests, Drugs, medications, biologicals, anesthesia and oxygen services, Private Duty Nursing when Medically Necessary, radiation

therapy, inhalation therapy, administration of whole blood, including the cost of blood, blood plasma, and blood plasma expanders, that are not replaced by or for You; and short-term rehabilitation therapy services in the Acute Hospital setting.

Payments of Inpatient Covered Expenses are subject to the following conditions:

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing semi-private room rate of the facility;
- services must be those which are regularly provided and billed by the Hospital;
- services are provided only for the number of days required to treat the Member's Illness or Injury; and
- concurrent care.

No Benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Outpatient Hospital Services

Benefits for the following Outpatient Services and treatments are available and may require Preauthorization. For Cost Sharing amounts and to determine if an Preauthorization is required, please refer to the **SCHEDULE OF BENEFITS**. These services include:

- ambulatory Surgery,
- diagnostic procedures, including laboratory, radiology, therapeutic radiology, and imaging,
- rehabilitation and radiation therapy, and
- Infusion Therapy.

Payments of Outpatient Hospital Covered Expenses are subject to these conditions:

- Outpatient services and supplies including those in connection with Emergency room services, Outpatient Surgery and Surgery performed at an Ambulatory Surgical Center.
- If shown on the **SCHEDULE OF BENEFITS**, an Emergency room visit, which does not result in an Inpatient Admission immediately following the Emergency room visit, is subject to the Emergency room visit Copayment, if any, in addition to any other applicable Copayment or Deductible.
- Care received when Outpatient Surgery is performed. Covered Services are operating room use, supplies, ancillary services, Drugs, and medicines. These services are also payable when an Outpatient Surgery is performed at an Ambulatory Surgical Center.
- Radiation therapy.
- Hemodialysis treatment.

Covered Prescription Drugs Billed Under the Medical Benefit

Covered Prescription Drugs obtained under the Medical Benefit may be subject to a separate Copayment or Coinsurance as listed in the **SCHEDULE OF BENEFITS**. If obtained in conjunction with other Medical Benefits (e.g., Office Visit, etc.), this may result in a separate Copayment or Coinsurance for the Covered Prescription Drug and other Medical Benefits (e.g., Office Visit, etc.). These Covered Prescription Drugs may require Preauthorization by the Medical Director in order to be covered as part of the Member's Medical Benefit.

Medical and Surgical Benefits

Benefits for the following surgical and medical services are available and may require Preauthorization. See the **SCHEDULE OF BENEFITS** to determine which services require Preauthorization. You must pay any applicable Deductible amounts and Coinsurance percentages shown on the **SCHEDULE OF BENEFITS**.

Surgery

The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by Us and is that period of time which is appropriate as routine care for the particular surgical procedure. When performed in the Physician's office, the Allowable Charge for the Surgery includes the Office Visit. No additional Benefits are allowed toward charges for Office Visits on the same day as the Surgery.

Reconstructive Surgery will be the same as for treatment of any other Sickness such as:

- treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Member;
- treatment provided for Reconstructive Surgery following cancer Surgery;

- Surgery performed on a Member for the treatment or correction of a congenital defect other than conditions of the breast;
- reconstruction of the breast on which mastectomy has been performed; Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; and
- Reconstructive Surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Bariatric Surgery

Weight loss Surgery will be covered if specifically Authorized by Us.

Incidental Procedure

An incidental procedure is one carried out at the same time as a more complex primary procedure, and which requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure. The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered. Surgical treatment for complications resulting from non-covered procedures are not covered.

Unbundled Procedure

Unbundled procedures occur when two (2) or more procedure codes are used to describe Surgery performed when a single, more comprehensive procedure code exists that accurately describes the entire Surgery performed. The unbundled procedures will be re-bundled for assignment of the proper comprehensive procedure code as determined by Us. The Allowable Charge includes the re-bundled procedure. We will provide Benefits according to the proper comprehensive procedure code for the re-bundled procedure, as determined by Us.

Mutually Exclusive Procedure(s)

Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made. The Allowable Charge includes all procedures performed at the same surgical setting. Procedure(s), which are not considered Medically Necessary, will not be covered.

Organ & Tissue Transplants

Benefits are payable for Hospital and Professional Services for Covered Services and supplies provided to a Member but only if all the following conditions are met:

- the transplant procedure is not Experimental/Investigational in nature;
- donated human organs or tissue or an FDA-approved artificial device is used;
- the transplant procedure is Preauthorized as required under the Plan;
- the Member meets all of the criteria established by MHHIC in pertinent written medical policies; and
- the covered Member meets all of the protocols established by the Hospital in which the transplant is performed.

Benefits are payable for Hospital and Professional Services for a:

- Member who is a recipient of the FDA-approved organ or tissue;
- Member who donates the FDA-approved organ or tissue; and
- FDA-approved organ or tissue donor who is not a Member, but the FDA-approved organ or tissue recipient is a Member.

Covered Services and supplies ‘related to’ an organ or tissue transplant include, but are not limited to x-rays, laboratory testing, chemotherapy, radiation therapy, Prescription Drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.
Benefits are payable only after Benefits have been paid for the Member’s expenses, and then only to the extent Benefits are available under the recipient’s Certificate of Coverage.

Exceptions:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply, or device which is found by Us to be Experimental, Investigative, or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for transplant of an organ procured from China or another country known to have participated in forced organ harvesting, as designated by the commissioner of state health services.
- Charges for a transplant that was performed in China or another country known to have participated in forced organ harvesting.
- Charges for non-FDA-approved mechanical devices designed to replace human organs. Use of an FDA-approved mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine are Covered Expenses.
- Charges incurred for keeping a donor alive for a transplant operation.
- Charges for personal comfort or convenience items.
- Alcohol, Drugs, or tobacco.

Assistant Surgeon

An assistant surgeon is a Physician who actively assists the operating surgeon and may be necessary because of the complex nature of the procedure(s) for the Member's condition. An assistant surgeon may be a licensed Physician Assistant, Certified Registered Nurse First Assistant (CRNFA), Registered Nurse First Assistant (RNFA) or Certified Nurse Practitioner. Coverage for an assistant surgeon is provided only if the use of an assistant surgeon is required with reference to nationally established guidelines. The Allowable Charge for the assistant surgeon is based on a percentage of the fee paid to the primary surgeon.

Anesthesia

General anesthesia services are covered when requested by the operating Physician and performed by a Certified Registered Nurse Anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless We determine otherwise.

Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

Second Surgical Opinion

Second surgical opinions with an in-network Provider are covered subject to any applicable Copayments, Coinsurance, and Deductible amounts, but are not mandatory in order to receive Benefits.

Oral Surgery Benefits

Coverage is provided for Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaw, cheeks, lips, tongue, roof, or floor of mouth, and of sound natural teeth. (For the purposes of this subsection, sound natural teeth include those that are capped, crowned, or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.) Coverage includes:

- incision and drainage of abscess and treatment of cellulitis;
- incision of accessory sinuses, salivary glands, and salivary ducts;
- excision of exostoses or tori of the jaws and hard palate;
- excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof, and floor of mouth;

- extraction of impacted teeth;
- Medically Necessary extractions in preparation for radiation treatment;
- anesthesia for the above services or procedures when rendered by an oral surgeon;
- anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia;
- anesthesia when rendered in a Hospital setting and for associated Hospital charges when Your mental or physical condition requires Dental Treatment to be rendered in a Hospital setting; and
- anesthesia Benefits for Temporomandibular Joint (TMJ) are provided for a condition that is the result of an accident, a trauma, a congenital defect, a developmental defect, or pathology.

Biomarker Testing

Biomarker testing allows providers to use information about a person's specific genetic variations to inform better diagnosis, prognosis, and therapy selection for cancer or rare disease patients. The Plan provides for unlimited biospecimen samples and biopsies.

Coverage for biomarker testing to diagnose, treat, manage, or monitor a medical condition is provided if clinical use of the test for the condition:

- is evidence based;
- is scientifically valid;
- informs the patient's outcome or provider's clinical decision; or
- predominantly addresses the Acute or Chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

The Plan provides coverage in a manner that limits disruption of care, including limiting the number of biopsies and biospecimen samples.

Pregnancy, Pediatrics and Reproductive Benefits

Pregnancy

Pregnancy Care and Newborn Benefits are available to a Member whose coverage is in effect at the time such services are furnished in connection with her pregnancy. Post-delivery care for a Member who is discharged before the expiration of the minimum hours of coverage may be provided at:

- the Member's home;
- a Provider's office;
- a healthcare facility; or
- another location determined to be appropriate under rules adopted by the Commissioner.

This Certificate of Coverage pays for pregnancies the same way We would cover an Illness, except for any exceptions listed below. The charges We cover for delivery and Newborn Child are explained below.

Surgical and Medical Services

MHHIC covers the following surgical and medical services for expecting Members when supported by a Medical Doctor (MD):

- Initial Office Visit and visits during the term of the pregnancy;
- Diagnostic Services;
- Delivery, including necessary pre-natal and post-natal care. Birthing centers only covered if supported by Physician back up coverage 24 hours a day; and
- Abortion performed:
    - when a Physician has certified, in the exercise of reasonable medical judgment, that the Member has a Life-Threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the Member at risk of death or poses a serious risk of substantially impairing a major bodily function unless the abortion is performed or induced; and
    - in compliance with applicable law.

Elective deliveries prior to the thirty-ninth (39th) week of gestation are not covered unless shown to be Medically Necessary. Facility and other charges associated with an elective early delivery that is not Medically Necessary are also considered to be non-covered.

Prenatal Care

In addition to periodic routine prenatal Office Visits with Your Provider, prenatal care may also include:

- screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
- comprehensive lactation support and counseling by a trained Provider during pregnancy and/or in the postpartum period; and
- rental and Preauthorization required for purchase of breastfeeding equipment not to exceed $500.

Facility Services

Pregnancy Care Benefits for Hospital services required in connection with pregnancy and abortions (as described above) are subject to the Benefit period Deductible amount and applicable Coinsurance percentage shown on the **SCHEDULE OF BENEFITS**. The Hospital (nursery) charge for Well-Baby Care is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.

Concurrent review or Precertification of the Hospital stay days is required for a Hospital stay in connection with childbirth for the covered mother or covered well Newborn Child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a Newborn's stay exceeds that of the mother. Notification of Admission and concurrent review or precertification of the Hospital stay days is also required for a Newborn that is admitted separately because of neonatal complications.

Complications of Pregnancy

Complications of pregnancy are covered under this Certificate of Coverage as any other medical condition. Such complications include conditions, requiring Hospital care, whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy. Diagnoses include, but are not limited to:

- Acute nephritis.
- Nephrosis.
- Cardiac decompression.
- Missed abortion and similar medical and surgical conditions of comparable severity.

Complications of pregnancy also include non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. They do not include elective cesarean section, false labor, occasional spotting, morning Sickness, Physician prescribed rest during the period of pregnancy, hyperemesis gravidarium, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Newborn Care

A Newborn is covered at birth as a Dependent. Surgical and medical services rendered by a Physician; for treatment of Illness; pre-maturity; post-maturity; or congenital condition of a Newborn and circumcisions are included. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered. Newborns are covered for the administration of a Newborn screening test. Coverage is provided for the cost of the test kit used to perform the screening in the amount required by Texas Health and Safety Code §33.019.

Hospital services, including services related to circumcision during the Newborn's post-delivery stay and treatment of Illness, pre-maturity, post-maturity, or congenital condition of a Newborn are covered. Charges for Well Baby and well Child care Benefits will be provided consistent with those Benefits listed in this Certificate of Coverage. The Hospital (nursery) charge for a well Newborn is included in the mother's Hospital bill for the covered portion of her Admission for Pregnancy Care.

When a Child is born to a Member with Subscriber only coverage, the Child is granted 61 days of automatic coverage on the Certificate of Coverage from the date of birth and the Deductible will increase from an individual Deductible to a Family Deductible. The Claim for the delivery charges may be applied to the new Family Deductible. The Family Deductible amount, as shown on the **SCHEDULE OF BENEFITS**, applies to all charges when a Newborn is added to a Certificate of Coverage of a Subscriber with a Family Certificate of Coverage.

Newborns are covered for screening tests for hearing loss from birth through the date the Child is 61 days of age as well as necessary diagnostic follow-up care related to the screening test from birth through the date the Child is 24 months of age.

Diagnosis of Infertility

The evaluation and diagnosis of Infertility is covered under this Certificate of Coverage as any other medical condition. However, services or supplies related to the treatment of Infertility are not covered including, but not limited to:

- In vitro gamete intrafallopian tube transfer (GIFT) or zygote intrafallopian tube transfer (ZIFT) procedures uterine embryo lavage;
- Embryo transfer;
- Artificial insemination;
- Cost for ovum donor, donor sperm, or sperm storage;
- Cryopreservation and storage of embryos;
- Ovulatory predictor kits;
- All costs related to surrogate motherhood;
- Low tubal ovum transfer; and
- Drug, infusion, or hormonal therapy.

Sterilization

Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy and hysteroscopic placement of micro-inserts into the fallopian tubes. Tubal ligation, salpingectomy, and hysteroscopic placement of micro-inserts into the fallopian tubes are available as a Preventive or Wellness Care Benefit. The reversal of tubal ligation or reversals of vasectomies are not covered.

Reproductive Benefits/Family Planning

All Prescription contraceptives or contraceptive devices approved by the FDA are covered.

Fertility preservation services are covered for a Member who will receive a Medically Necessary treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility.

Accidental Injuries - Dental

Dental Care for an Accidental Injury to natural teeth is covered under this Certificate of Coverage. Damage to natural teeth due to chewing and biting is not considered an Accidental Injury.

In addition, this Certificate of Coverage provides Benefits for up to three (3) days of Inpatient Hospital services when a Hospital stay is ordered by a Physician and a dentist for Dental Treatment required due to an unrelated medical condition. We determine whether the Dental Treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary, unless the Member is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Member's Physician or by the dentist providing the Dental Care.

General Provisions

- Any medical treatment which is necessary in conjunction with Dental Care because of the general health and physical limits of the Member as indicated by said Member's personal Physician or the MHHIC dentist.
- Any treatment requested or appliance made which in the opinion of the treating dentist is not necessary for maintaining or improving the Member's health.
- Any treatment covered or provided for by Workers' Compensation or Employer's liability laws by a federal or state government agency or provided without cost by any municipality, county, or other governmental subdivision.
- Any procedure considered to be Experimental or Investigational is eligible for External Review.
- Any Dental Care provided by a Out-of-Network Provider general dentist or Specialist except when Authorized by MHHIC.

- Dental Treatment and expenses incurred for such treatment started prior to the Member's eligibility to receive Benefits under this Certificate of Coverage, or started after a Member's termination.

Specific Provisions

- Replacement of lost or stolen Prosthetic Devices. Dentures or appliances will be replaced only after 5 years have elapsed since such dentures or appliances were provided under any MHHIC program unless the denture becomes unsatisfactory due to Illness or other causes not controlled by ordinary circumstances. Replacement under this Certificate of Coverage will be made only if the existing denture is unsatisfactory and cannot be made satisfactory.
- Mouth guards or TMJ devices require Preauthorization.
- Prophylaxis, adult/Child: once every 6 months unless required more often due to dental necessity as determined by Member's primary dental Provider.
- Full mouth x-rays: once every 36 months unless required more often due to dental necessity as determined by Member's primary dental Provider.
- Panoramic x-rays: once every 36 months unless required more often due to dental necessity as determined by Member's primary dental Provider.
- Special requests by patients for titanium partial dentures, personalized and cosmetic full dentures, or partial dentures (including gold for all removable appliances) differing from standard full or partial dentures will be provided at additional fees determined by the dentist.

Orthodontic Exclusions & Limitations

- Replacement of appliances due to theft, loss, or breakage.
- Re-treatment by an MHHIC dentist when the original treatment was done by a different MHHIC dentist or treatment in progress at inception of eligibility unless treatment is continued by an MHHIC dentist.
- Failure to follow prescribed treatment or accidents occurring during the treatment.
- If Your coverage terminates, You will be responsible for payment of the balance due for treatment at the dentist's normal fee.
- Special requests by patients for braces differing from standard braces for cosmetic purposes will be provided at additional fees determined by the dentist.

Mental Health & Substance Abuse

Mental Health

We cover mental health care services relating to the diagnosis and treatment of Mental (including serious mental Illness), Nervous and Emotional Disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate of Coverage. Additionally, We provide coverage for treatment in a Residential Treatment Center for Children and adolescents or a Crisis Stabilization Unit that is at least as favorable as the coverage We provide for treatment of Mental or Emotional Illness or Disorder in a Hospital. Serious Mental Illness as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) includes, but is not limited to the following psychiatric Illnesses:

- schizophrenia;
- paranoia and other psychotic disorders;
- bipolar disorders (mixed, manic, hypomanic, and depressive);
- major depressive disorders (single episode or recurrent);
- schizo-affective disorders (bipolar or depressive);
- obsessive-compulsive disorders;
- depression in childhood and adolescence; and
- clinical diagnosis of Alzheimer's disease by a Physician licensed in Texas pursuant to the Insurance Code Chapter 1354 as proof of an organic disease.

In order to qualify for Benefits, services for Mental, Emotional, or Functional Nervous Disorders must meet the following conditions of service:

- services must be for the treatment of a Mental, Emotional, or Functional Nervous Disorder that can be improved by standard medical practice;
- the Member must be under the direct care and treatment of a Physician for the condition being treated'
- services must be those which are regularly provided and billed by a Hospital;
- services are provided only for the number of days required to treat the Member's condition; and

- services must be received in a Hospital, Psychiatric Day Treatment Facility, Crisis Stabilization Unit or Residential Treatment Center.

We also provide Inpatient mental health care services relating to the diagnosis and treatment of Mental, Emotional, or Functional Nervous Disorders at facilities that provide residential treatment including room and board charges. Coverage for Inpatient services for mental health care is limited to facilities such as:

- a psychiatric center or Inpatient facility under the jurisdiction of the Texas Department of State Health Services;
- a state or local government-run psychiatric Inpatient facility;
- a part of a Hospital providing Inpatient mental health care services under an operating certificate issued by the Texas Department of State Health Services; and
- a comprehensive psychiatric Emergency program or other facility providing Inpatient mental health care that has been issued an operating certificate by the Texas Department of State Health Services.

Each two days of treatment in a Psychiatric Day Treatment Facility, Crisis Stabilization Unit or Residential Treatment Center will be considered equal to one day of treatment in a Hospital or Inpatient program. There shall be no imposition of any quantitative or non-quantitative treatment coverage limits that are more restrictive than those imposed on Benefits for medical or surgical expenses.

Chemical Dependency (Substance Use Disorder)

Chemical Dependency is the abuse of or psychological or physical dependence on or addiction to alcohol, a toxic inhalant or substance designated as a controlled substance in the Texas Health and Safety Code.

Benefits for treatment of substance abuse are available. Covered Services will be only those which are for treatment for abuse of alcohol, Drugs, or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. There shall be no imposition of any quantitative or non-quantitative treatment coverage limits that are more restrictive than those imposed on Benefits for medical or surgical expenses.

Covered Services are shown below for the treatment of Chemical Dependency:

- Inpatient Hospital services as stated in the **Hospital** provision of this chapter for detoxification or rehabilitation.
- Hospital services for Partial Hospitalization.
- Inpatient and Outpatient services in a Chemical Dependency Treatment Center.
- Physician's visits during a covered Inpatient stay or for intensive Outpatient treatment.

Inpatient substance use services are limited to facilities in Texas which are certified by the Texas Department of State Health Services and those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs. We do not pay for Custodial Care, education, or training. There shall be no imposition of any quantitative or non-quantitative treatment coverage limits that are more restrictive than those imposed on Benefits for medical or surgical expenses.

Rehabilitative and Habilitative Therapy

Rehabilitative and Habilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, and/or Chiropractic Services. Benefits are available when these services are rendered by a Provider licensed and practicing within the scope of his license. Rehabilitation and services that, in the opinion of the Network Physician are Medically Necessary, will not be denied, limited, or terminated as long as they meet or exceed treatment goals for You or Your covered Dependent in accordance with an Individual Treatment Plan. For a physical disability, treatment goals may include maintenance of functioning, prevention of deterioration, or slowing of further deterioration.

Cardio/Pulmonary Therapy

Cardio/Pulmonary Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered. The therapy must be used to restore cardiac or pulmonary function.

Occupational Therapy

Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to, a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.

Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services. Benefits for eligible treatment by an occupational therapist are limited to one (1) visit per day and are payable subject to the maximum Benefit limits shown on the **SCHEDULE OF BENEFITS** per Member per Year.

Physical Therapy

Members are also covered for eligible services by a Physician for any combination of Physical Therapy or Medicine as noted on the **SCHEDULE OF BENEFITS**. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of service unless performed under the following circumstances:

- to Children with a diagnosed developmental disability pursuant to the Member's plan of care;
- as part of a Home Health Care agency pursuant to the Member's plan of care;
- to a patient in a nursing home pursuant to the Member's plan of care; and
- related to conditioning or to providing education or activities in a Wellness setting for the purpose of Injury prevention, reduction of stress, or promotion of fitness.

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet, manipulation of the spine, manual or electrical muscle stimulation, spinal or other manipulative or ultrasound therapy for vertebrae, disc, spine, back and neck, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the combined maximum payment and number of visits as stated above. The term "visit" includes any Outpatient visit to a Physician during which one or more Covered Services are provided and subject to limitation per Benefit Year as shown on the **SCHEDULE OF BENEFITS**.

Additional visits for Physical and/or Occupational Therapy/Medicine may be covered if:

- this follows an Inpatient Hospitalization following severe trauma such as spinal Injury or stroke; and
- We determine that additional treatment is likely to result in significant improvement by measurably reducing the Member's impairment; and
- We Authorize services prior to being delivered.

Hearing Aids/Cochlear Implants/Speech/Language Pathology Therapy

Hearing aids or cochlear implants are covered. Coverage includes fitting and dispensing services and the provision of ear molds as necessary to obtain optimal fit of hearing aids, treatment for habilitation and rehabilitation and for cochlear implants, external speech processor and controller with necessary component and replacement every three (3) Years.

Benefits for Covered Expenses will be provided for speech and hearing therapy and the necessary care and treatment of loss or impairment of speech or hearing. This includes services of a Physician for speech and hearing therapy, hearing examinations and hearing aids. Hearing aids are limited to one pair every 36 months. Services for hearing aids do not require Preauthorization when provided by a Network Provider or when out-of-network Benefits are available in Your Plan. Cochlear implants require Preauthorization.

Speech/Language Pathology Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered and included, but not limited to, a speech pathologist or by an audiologist. The therapy must be used to improve or restore speech language deficits or swallowing function.

Chiropractic Services

A licensed chiropractor may make recommendations for a patient regarding symptoms, prescribed treatment, diagnostic procedures, and results for the treatment of a neuromusculoskeletal condition associated with the functional integrity of the spine. Frequency, duration, and results of planned treatments are documented with an anticipated length of treatment and quantifiable long- and short-term goals provided.

Early Intervention Services for Treatment of Developmental Delays for Children

Early intervention services are Medically Necessary Speech and Language Therapy, Occupational Therapy, Physical Therapy and assistive technology services and devices for covered Dependents from birth to age three (3) years. Early intervention services for treatment of developmental delays for covered Children under three (3) years of age will not be subject to any Plan limits for Physical and/or Occupational Therapy.

Payment for Medically Necessary early intervention services for treatment of diagnosed developmental delays will be provided to a covered Dependent Child under three (3) years of age, who is certified by the Department of State Health Services as eligible for services under Part H of the Individual with Disabilities Education Act, for Rehabilitative and Habilitative therapies prescribed by a Physician including:

- Occupational Therapy evaluations and services;
- Physical Therapy evaluations and services;
- Speech Therapy evaluations and services;
- Dietary or nutritional evaluations; and
- Services designed to help the Child attain or retain the capability to function age-appropriately within his/her environment, including services that enhance functional ability without affecting a cure.

Habilitative Services for Children are covered, subject to applicable Plan limits, from age three (3) years through the end of the month in which the Child turns nineteen (19) years of age.

Skilled Nursing Facility

For any eligible condition, and with Preauthorization from the Plan, We will pay Covered Expenses for Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility. Payment of Benefits for Skilled Nursing Facility services are subject to all of the following conditions:

- the Member must be referred to the Skilled Nursing Facility by a Physician;
- services must be those which are regularly provided and billed by a Skilled Nursing Facility;
- the services must be consistent with the Member's Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury; and
- the Member must remain under the active medical supervision of a Physician treating the Illness or Injury for which the Member is confined in the Skilled Nursing Facility.

No Benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Home Health Care

When Home Health Care can take the place of Inpatient care, We cover such care furnished to a Covered Person under a written Home Health Care plan. Benefits are provided when You or Covered Dependents are under the active supervision of a Physician who certifies that Hospitalization or confinement in a skilled facility would be required if a treatment plan for Home Health Care were not provided, subject to the maximum Benefit limits shown on the **SCHEDULE OF BENEFITS**. The Physician must be treating the Illness or Injury that necessitates Home Health Care and he or she must renew any order for these services at least once every two (2) months. We cover all Medically Necessary and appropriate services or supplies, such as:

- Routine nursing care furnished by or under the supervision of a Registered Nurse;
- Physical Therapy;
- Occupational Therapy;
- Medical social work;
- Nutrition services;
- Speech Therapy;
- Home health aide services;
- Medical appliances and equipment, Drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Certificate of Coverage if the Covered Person had been in a Hospital;
- Any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a practitioner's office, or any other licensed health care facility, provided such service would have been covered under the Certificate of Coverage if performed as Inpatient Hospital services; and

- Home Health services and supplies directly related to Infusion Therapy are included in the Infusion Therapy Benefit and are not payable under this Home Health Care Benefit.

Payment is subject to all of the terms of this Certificate of Coverage and to the following conditions:

- The Covered Person's practitioner must certify that Home Health Care is needed in place of Inpatient care in a recognized facility. Home Health Care is covered **only** in situations where continuing Hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if Home Health Care were not provided.
- The services and supplies must be:
    - ordered by the Covered Person's practitioner;
    - included in the Home Health Care plan; and
    - furnished by, or coordinated by, a home health agency according to the written Home Health Care plan.

Services must be provided by a home health agency or a visiting nurse association. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term (no more than three-day) basis. The Home Health Care plan must be set up in writing by the Covered Person's practitioner within 14 days after Home Health Care starts and it must be reviewed by the Covered Person's practitioner at least once every 60 days.

We do not pay for:

- services furnished to Family members, other than the patient; or
- services and supplies not included in the Home Health Care plan.

Hospice Services

Hospices are palliative care Providers that are licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as Hospice Providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

The Member must be suffering from a terminal Illness, as certified by the attending Physician and submitted to Us in writing. The Physician must consent to the Member’s care by the Hospice and must be consulted in the development of the Member’s treatment plan. The Hospice must submit a written treatment plan to Us every 30 days. Inpatient Hospice services require Authorization by the Plan.

To be eligible for this Benefit, the Provider must be appropriately licensed according to state and local laws to provide skilled nursing and other counseling services to support and care for persons experiencing the final phases of terminal Illness. The Provider must also be approved as a Hospice Provider under Medicare and the Joint Commission on Accreditation of Hospitals or by the appropriate agency in the State of Texas.

We do not cover expenses for the noted:

- Services and supplies provided by volunteers or others who do not regularly charge for their services;
- Funeral services and arrangements;
- Legal or financial counseling or services;
- Treatment not included in the Hospice Care Plan; and
- Services supplied to Family Members who are not Covered Members, except for services related to bereavement counseling.

Palliative Care

Palliative care provides services for symptom management or curative treatment of a primary Illness, as well as psychological support in dealing with an Illness. It can include care such as pain management, counseling, and nutrition advice. It can also include helping You to:

- Better understand Your Illness.
- Decide what treatment You do or do not want.
- Communicate more effectively with Your Providers and Your Family.
- Openly discuss Your feelings about Your Illness.

Palliative care services can be provided in a Hospital, Physician's office, Skilled Nursing Facility, or in a Member's home.

Centers of Excellence Features

A "Center of Excellence" is a Provider that has entered into a Certificate of Coverage with MHHIC to provide health Benefit services for specific procedures. A Member must undergo a pre-treatment screening evaluation to review past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Member is an appropriate candidate for the surgical procedure(s) or medical therapy performed at the Center of Excellence. In order for charges to be Covered Charges, the Center of Excellence must:

- Perform a pre-treatment screening evaluation; and
- Determine that the procedure is Medically Necessary and appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be subject to the terms and conditions of this Certificate of Coverage.

Other Benefits & Services

Treatment for Diabetes - Equipment and Supplies

We cover: blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by or adapted for legally blind persons; test strips specified for use with a corresponding glucose monitor; lancets and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated supplies, which include: insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; other required disposable supplies; podiatric appliances, including therapeutic footwear, for the prevention of complications associated with diabetes; glucagon Emergency kits; Prescription medications that bear the legend "Caution: Federal Law Prohibits Dispensing Without a Prescription" and medications available without a Prescription for controlling blood sugar levels; and repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which will exceed the purchase price of a similar replacement pump.

Continuous Glucose Monitors (CGMs) are covered on Your Pharmacy Benefit as noted on the **SCHEDULE OF BENEFITS** and Capital Rx Formulary. Our preferred continuous glucose monitor is Dexcom. All other CGMs are subject to review of Medical Necessity. Please check the Formulary for the most current or updated product information.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies will be covered if determined to be Medically Necessary and appropriate by a treating Physician or other health care practitioner through a written order. All supplies, including medications and equipment for the control of diabetes, will be dispensed as written, including brand name products, unless substitution is approved by the Physician or other health care practitioner who issues the written order for the supplies or equipment.

Diabetes Education and Training for Self-Management

Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, or non-insulin diabetes may need to be educated on their condition and trained to manage their condition.

Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the Member's Physician.

Evaluations and training program for diabetes self-management are covered subject to a determination by a Physician that the program must be Medically Necessary and provided by a licensed health care professional who certifies that You have successfully completed the training program.

The program will comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Mastectomy and Related Procedures

Benefits are payable for Hospital and Professional Services under this Plan for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy including lymphedemas, whether or not the mastectomy occurred while the Member was covered under this Plan.

Benefits will be provided for Covered Expenses for Inpatient Hospital care for a minimum of 48 hours following a mastectomy, and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If You elect breast reconstruction in connection with any mastectomy, Benefits will also be provided for Covered Expenses for the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and services and other supplies necessary for any physical complication, including lymphedemas and removal of implants at all stages of the mastectomy.

These Covered Services will be delivered in a manner determined in consultation with You and the attending Physician and, if applicable, will be subject to any Deductible and Coinsurance.

Acquired Brain Injury

Medical services for Acquired Brain Injury are paid on the same basis as any other medical condition, except that services and supplies provided by a Skilled Nursing Facility or services or supplies for any kind of covered Outpatient therapy for Acquired Brain Injury are covered only under this Benefit and are subject to the Benefit maximums shown on the **SCHEDULE OF BENEFITS**.

Benefits will be provided for Covered Services as a result of and related to an Acquired Brain Injury, which include: Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neurophysiological, Neuropsychological, and Psychophysiological Testing or Treatment, Neurofeedback Therapy, Remediation, Post-Acute Transition Services, or Community Reintegration Services, including Outpatient Day Treatment Services or other Post-Acute Care Treatment Services.

Post-Acute Care Treatment includes coverage for the reasonable expenses related to periodic reevaluation of the care of a Member covered under the Plan who has incurred an Acquired Brain Injury and:

- has been unresponsive to treatment; and
- becomes responsive to treatment at a later date.

Determination of whether the above expenses are reasonable will include consideration of factors including:

- cost and the time elapsed since the previous evaluation;
- any differences in the expertise of the Physician or practitioner performing the evaluation;
- changes in technology; and
- advances in medicine.

Covered Services include testing, treatment and therapies provided to treat an Acquired Brain Injury. Therapy includes scheduled remedial treatment provided through direct interaction with the Member to improve a pathological condition resulting from an Acquired Brain Injury.

Telehealth, Telemedicine, Teledentistry Services

Telehealth, Telemedicine, and Teledentistry Services are covered at the same extent that We would provide coverage for an in-person setting.

- **Telehealth Service** is a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.
- **Telemedicine Medical Service** is a health care service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

- **Teledentistry Dental Service** is a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Urgent Care

An Urgent Care Clinic is a facility dedicated to the delivery of medical care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care Clinics are primarily used to treat patients who have non-life threatening, Acute Injuries or Illnesses that require immediate care, but are not serious enough to warrant a visit to an Emergency room. A clinic may be staffed by doctors trained in primary or Emergency medicine.

Choosing an Urgent Care Clinic over an Emergency room can save You time and money. Refer to the **SCHEDULE OF BENEFITS** for Your Cost Sharing amount.

Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for attention deficit/hyperactivity disorder is covered when rendered or prescribed by a Physician or allied health professional.

Autism Spectrum Disorders (ASD)

Coverage is provided for expenses relating to the treatment of Autism Spectrum Disorders. Additionally, coverage is provided for the screening of Autism Spectrum Disorders at the ages of 18 and 24 months. Treatment may include generally recognized services contained in a treatment plan recommended by the Member's primary Physician. Services may include, but are not limited to evaluation and assessment services; applied behavior analysis; behavior training and management; Speech, Physical and Occupational Therapy; medications or nutritional supplements used to address symptoms of the ASD.

An individual providing treatment for Autism Spectrum Disorder must be a health care practitioner or an individual acting under the supervision of a health care practitioner:

- who is licensed, certified, or registered by an appropriate agency in the State of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a Provider under the TRICARE military health system.

ASD Benefits are subject to the Deductible and Coinsurance amounts that are applicable to the Benefits obtained. (Example: A Member obtains Speech Therapy for treatment of ASD. Member will pay the applicable Deductible or Coinsurance amount shown on the **SCHEDULE OF BENEFITS** for Speech Therapy.)

Cleft Lip and Cleft Palate Services

The following services for the treatment and correction of cleft lip and cleft palate are covered:

- Oral and facial Surgery, surgical management, and follow-up care.
- Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.
- Orthodontic treatment and management.
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
- Speech-language evaluation and therapy.
- Audiological assessments and amplification devices.
- Otolaryngology treatment and management.
- Psychological assessment and counseling.
- Genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

Dietitian Visits

Benefits are available for visits to registered dietitians for all Members to keep You healthy. Diabetics that need the services of a dietitian should receive those services as part of their Benefits for diabetes education and training for self-management.

Disposable Medical Equipment or Supplies

Disposable medical equipment or supplies which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by Us. The equipment and supplies are subject to the Member's medical Deductible and Coinsurance.

Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances, Devices, and Services

Durable Medical Equipment

Durable Medical Equipment (DME) is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. Preauthorization is required for DME over $500. The equipment must not be provided mainly for the comfort or convenience of the Member or others. In addition, the equipment must meet all of the following criteria:

- it must withstand repeated use;
- it is primarily and customarily used to serve a medical purpose;
- it is generally not useful to a person in the absence of Illness or Injury; and
- it is appropriate for use in the patient's home.

Benefits for rental or purchase of Durable Medical Equipment include:

- Benefits for the rental of DME will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge).
- At the Company's option, Benefits will be provided for the purchase of DME, appropriate supplies, and oxygen required for therapeutic use. The purchase of DME will be based on the purchase Allowable Charge.
- Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Member selects deluxe equipment solely for his comfort or convenience.
- Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
- Accessories and medical supplies necessary for the effective functioning of covered DME are considered an integral part of the rental or purchase allowance and will not be covered separately.
- Repair or adjustment of purchased DME or for replacement of components is covered. Replacement of equipment lost or damaged due to neglect or misuse or for replacement of equipment within five (5) years of purchase or rental will not be covered.

Limitations in connection with Durable Medical Equipment:

- There is no coverage during rental of DME for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the DME supplier.
- There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.
- There is no coverage for repair or replacement of equipment lost or damaged due to neglect or misuse.
- Reasonable quantity limits on DME items and supplies will be determined by Us.

Orthotic Devices, Prosthetic Appliances & Devices

Benefits as specified in this subsection will be available for the purchase of Prosthetic Devices, Orthotic Devices and Professional Services related to the fitting and use of those devices that equals the coverage provided under federal laws for the aged and disabled.

Benefits are limited to the most appropriate model of Prosthetic Device or Orthotic Device that adequately meets the medical needs of the Member as determined by the Member's treating Physician, podiatrist, prosthetist, or orthotist. Benefits will be subject to the following:

- Repair or replacement of the Orthotic Device is covered unless the repair or replacement is necessitated by misuse or loss by the Member.
- Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Member selects a deluxe device solely for his comfort or convenience.

- Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.

Benefits for Prosthetic Appliances and Devices and Prosthetic Services of the limbs are the same as for non-limb with the addition of:

- A Member may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Certificate of Coverage and may pay the difference between the price of the device and the Benefit payable, without financial or contractual penalty to the Provider of the device.
- Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotics/Prosthetics Certification (BOC).

You are also covered for any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails, in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or Chronic arterial or venous insufficiency.

Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed in the home or in a Network-accredited sleep laboratory are eligible for coverage. Members should check their Provider directory or contact a Customer Service Representative at 855-645-8448 to verify that a sleep laboratory is accredited.

Clinical Trials

Benefits are provided to a Member for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening disease or condition and is described in any of the following subparagraphs:

- The study or investigation is approved or funded by one or more of the following:
  - The National Institutes of Health;
  - The Centers for Disease Control and Prevention;
  - The Agency for Health Care Research and Quality;
  - The Centers for Medicare & Medicaid Services;
  - Cooperative group or center of any of the entities described below:
    - The National Institutes of Health;
    - The Department of Defense;
    - The Department of Veterans Affairs;
    - The Department of Energy;
    - The Centers for Disease Control and Prevention;
    - The Agency for Health Care Research and Quality;
    - The Centers for Medicare & Medicaid Services;
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
  - An Institutional Review Board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services;
  - The United States Department of Energy, the Department of Veterans Affairs, or the Department of Defense if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
- The study or investigation is a Drug trial that is exempt from having such an investigational new Drug application;
- The study or investigation is conducted under an investigational new Drug application reviewed by the Food and Drug Administration.

Clinical Trial Limitations

We are not required to reimburse the Research Institution conducting the clinical trial for the cost of routine patient care provided through the Research Institution unless the Research Institution, and each health care professional providing routine patient care through the Research Institution, agrees to accept reimbursement under this Plan, at

the rates that are established under the Plan, as payment in full for the routine patient care provided in connection with the clinical trial and the treatment is pre-approved by MHHIC. We are also not required to provide Benefits for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

PRESCRIPTION DRUG BENEFITS

Covered Prescription Drugs and Other Medications

Coverage is available for Prescription Drugs if shown as covered on the **SCHEDULE OF BENEFITS**. The Prescription Drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist or a Pharmacy technician under the direction of a licensed pharmacist, upon the Prescription of a Physician or an allied health professional who is licensed to prescribe Drugs.

Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered.

As medically appropriate, the Medical Director or our designated review agent may require the substitution of any Prescription Drug for another Prescription Drug or form of treatment which, based upon the recommendations of the Pharmacy and Therapeutics Committee, and Our Medical Director's professional judgment, provides equal or better results at a lower cost.

Benefits for Medically Necessary covered Prescription Drugs prescribed to treat a Member for an Acute, Chronic, disabling, or Life-Threatening disease or condition are available under this Certificate of Coverage if the Prescription Drug is on the applicable Drug list and both of the following:

- has been approved by the Food and Drug Administration (FDA) for at least one indication; and
- is recognized for treatment of the indication for which the Drug is prescribed by the following:
  - a Prescription Drug reference compendium approved by the Commissioner of Insurance; or
  - substantially accepted peer-reviewed medical literature.

Certain Prescription Drugs may be subject to step therapy or require Prior Authorization or other coverage requirements as shown on the **SCHEDULE OF BENEFITS**. Refer to the **PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS** chapter of this Certificate of Coverage for details regarding Pharmacy Prescription Drug Benefit Exclusions.

Prescription Drug Formulary

A Prescription Drug Formulary, also known as the Drug List or Formulary List, is a list of Prescription Drugs covered under this Certificate of Coverage. As noted on the **SCHEDULE OF BENEFITS**, placement of Prescription Drugs on a Drug tier may be based on a Drug's quality, safety, clinical efficacy, available alternatives, and cost. We review the Prescription Drug Formulary at least once per Year.

We develop the Formulary and coverage for Prescription Drugs in in accordance with an evidence-based Formulary developed by Physicians and pharmacists comprising the Pharmacy and Therapeutics Committee, which reviews the scientific evidence, economic data, and a wide range of other information about Drugs for potential Formulary placement and coverage. Based upon that review, the committee selects the Prescription Drugs it believes to be the safest and most effective of those Prescription Drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost.

We will provide a 60-day notice upon coverage renewal if any modification is made to the Prescription Drug Formulary. If an approved or covered Drug is removed from the Drug Formulary before Your Plan renewal date, Your Drug will continue to be offered at the contracted Benefit level and until Your Plan renewal date.

Information about Your Formulary is available to You in several ways. Most Members receive information in the mail about their Prescription Drug coverage, including information about specific Drugs, cost, and Drug lists. We also have information available for You to print and discuss with Your doctor. You can view Your Pharmacy and Formulary information from Our website at: https://healthplan.memorialhermann.org/members/pharmacy-benefit-information.

You may also contact Us at (833) 502-3346 to ask whether a specific Drug is included in Your Formulary.

Formulary Categories and Legend

Copayments vary based upon the tier level a particular Drug has been placed on by the health Plan. **Please check the Formulary or Drug list for the latest updates or changes along with any special requirements (indicated**

under the Formulary Legend and Category of Drugs below). Utilize the legend at the bottom of each page if Your Drug or product contains a special code or indicator under the tier category and to view any additional restrictions or notes on a Drug.

- Category of Drugs:
  - Generic
  - Preferred Brands
  - Non-Preferred Brands/Drugs.
- Formulary Legend or Requirements:
  - S: Specialty Drugs - Specialty Drugs are high-cost Drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.
  - QL: Quantity Limit - There is a limit on the amount of this Drug that is covered per Prescription, or within a specific time frame.
  - QLC: Quantity Limit (Custom) - There is a limit on the amount of this Drug that is covered per Prescription, or within a specific time frame.
  - ACA: Affordable Care Act
  - ST: Step Therapy - In some cases, You may be required to first try certain Drugs to treat Your medical condition before we will cover another Drug for that condition.
  - PA: Prior Authorization - You (or Your physician) are required to get Prior Authorization before You fill Your Prescription for this Drug. Without prior approval, we may not cover this Drug.
  - AL1: Age Limit - This Prescription Drug may only be covered if You meet the minimum or maximum age limit.
  - GL: Gender Limit - This Prescription Drug may only be covered for a single gender.
  - HCB: High-Cost Brand
  - HCG: High-Cost Generic
  - CK: Compound Kit
  - X: Drugs or products that are a Plan Benefit Exclusion from coverage.
  - NF: Drugs or products that are not covered on the Formulary, but You can request coverage through a Prior Authorization request.

Generic and Brand Drugs

Many Prescription Drugs are available in Generic form, which is more cost effective for Members. It may be to the Member's advantage to ask the Physician to prescribe, and the pharmacist to dispense Generic Drugs whenever possible.

Generic Drugs are Drugs on the Formulary that require the lowest Copayment. Formulary Brand Prescription Drugs are also on the Formulary and may require an increased Copayment or Coinsurance. If the Member requires the use of Generic-equivalent Drugs and the Member receives a Brand Name Prescription Drug when a Generic equivalent is available, then the Member will pay no more than the Generic Copayment plus the difference between the cost of the Generic Drug and the cost of the Brand Name Prescription Drug, even when the Prescription is written "dispense as written". This is known as a brand Cost Share differential or penalty and any amounts paid towards this are not applied to the Maximum Out of Pocket and You will continue to incur this cost even if You meet the Maximum Out of Pocket.

Copayments for Generic Drug(s) will be no more than the Generic Drug Copayment. Additionally, if the negotiated or Usual and Customary cost of the Generic Drug is less than the Copayment, You may only be required to pay the lower cost. You will never pay any amount greater than the lesser of the allowable Copayment, the allowable Claim amount, or the cost of the Drug if You had purchased without using this Plan.

In most cases, there are Generic and/or Preferred Brand Name alternatives for Non-Preferred Brand Name Drugs. Brand Prescription Drugs with a Generic equivalent may not be covered by Us and require Prior Authorization. Discuss the possibility of being prescribed a Preferred Brand Name or Generic Drug with the Physician, if appropriate. The Drug Formulary (or Drug List) contains a list of products that are covered by the Plan. We recommend using this list to discuss treatment options with Your health care Provider or Physician. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your Physician or other Authorized prescriber will prescribe the Drug for a particular medical condition or mental Illness.

Prescription Drugs, which are non-preferred or Non-Formulary, may not be covered by Us or may require the larger Coinsurance or Copayment, depending on the Plan selected, and may have a Prior Authorization requirement or other restrictions. To request coverage for a non-Formulary medication, A Member, or the prescribing Provider or health professional must submit a request for Prior Authorization to the Utilization Review agent for consideration of coverage. If the request is denied, the decision is considered an Adverse Determination and the Member has the right to Appeal. Refer to https://healthplan.memorialhermann.org/members/pharmacy-benefit-information for details regarding the Appeal submission process for Pharmacy Drugs.

Diabetes Supplies and Continuous Blood Glucose Monitors

The Plan includes Benefits for Medically Necessary Diabetic Supplies including insulin syringes when prescribed and dispensed for use with insulin or for self-administration with a covered Drug or injectables.

The preferred diabetic test strip products are OneTouch (Lifescan) and Contour (Ascensia) test strips. Please check the Formulary for any restrictions and tier information.

Continuous blood glucose monitors (CGMs) are covered through Your Pharmacy Benefit, please check the Formulary for any restrictions and tier information. Our preferred continuous glucose monitor is DexCom. All other CGMs are subject to review of Medical Necessity.

Insulin/insulin analogs and supplies (e.g., needles, syringes, cartridges, prefilled pens, glucose meters and/or test strips, continuous glucose meter supplies) are allowed for the lesser of a 30-days' supply or smallest package size when specified conditions are met per Texas law.

Specialty Drugs

Prescription Drugs designated on the Drug Formulary as Specialty Pharmacy Drugs must be dispensed from one of the Network Specialty Pharmacy Providers. Specialty Prescription Drugs dispensed by a Network Specialty Pharmacy Provider will be subject to the Formulary Copayment for Specialty Prescription Drugs as specified in the **SCHEDULE OF BENEFITS** and may be limited to a 30-day supply maximum. Failure to obtain Specialty Prescription Drugs from the Network Specialty Pharmacy Provider may result in denial of coverage for the Specialty Prescription Drug. Drugs on the health Plan Formulary and Specialty Pharmacy Drugs may require Prior Authorization and may be subject to other coverage requirements or may be on a limited distribution list. We encourage You to fill Your Specialty Pharmacy Prescriptions at Memorial Hermann Specialty Pharmacy or at Costco Specialty Pharmacy.

For more information on the Specialty Pharmacies and how to see if Your medications are covered or to get started, visit the FAQ document on Our website at: https://healthplan.memorialhermann.org/members/commercial-pharmacy-benefits-and-services/pharmacy-benefit-faq.

Other Conditions of Service

The Drug or medicine must be:

- prescribed in writing by a Physician and dispensed within one (1) year (or less) of being prescribed, subject to federal or state laws;
- approved for use by the Food and Drug Administration with an appropriate indication;
- for the direct care and treatment of the Member's Illness, Injury, or condition (Dietary supplements, health aids or Drugs for cosmetic purposes are not included); and
- purchased from a licensed Pharmacy or ordered through the mail order program in accordance with this Certificate of Coverage.

The Drug or medicine must not be used while the Member is an Inpatient in any facility.

Authorization Requirements

Certain medications have restrictions in place to ensure they are being used appropriately and safely. Such restrictions may include:

- Quantity limits on the amount of a Prescription Drug the Member can receive over a period.
- Step therapy requiring trial of an alternative Prescription Drug(s) before a Prescription Drug is covered.

- Prior Authorization requires the provider to submit documentation that the Prescription Drug is Medically Necessary before a Prescription Drug is covered.

Utilization Review Program

Certain Drugs may require Utilization Review and have Authorization requirements. If there are patterns of over-utilization or misuse of Drugs, we will notify Your Physician or pharmacist. We reserve the right to limit Benefits to prevent over-utilization of Drugs. If a Member fills a Prescription for a Drug that requires Utilization Review, the Member will receive a letter informing him/her of the requirement, and of how to obtain approval for any refills.

Changes to Utilization Review requirements such as Prior Authorization changes will be posted to Our website at least 5 days before changes are implemented. You can view these changes at the Medication Management section of Our webpage at: https://healthplan.memorialhermann.org/members/commercial-pharmacy-benefits-and-services/utilization-management-appeals-grievances.

Please refer to the subsection titled *Formulary Categories and Legend* in this chapter to see how these restrictions are marked on Our Formulary list. For information on which specific Drugs require Utilization Review, call the toll-free number shown on the **CONTACT INFORMATION** page at the beginning of this Certificate of Coverage.

Step Therapy

The main goal of step therapy is to promote safer, more cost-effective treatment by encouraging a "step" approach in evaluating Prescription Drug use. To receive the maximum Plan Benefit, You may first need to try a proven, cost-effective option before engaging in a newer treatment that may be higher-cost and higher-risk.

Some Drugs require step therapy. This means that You must try one or more other Drugs before a step therapy Drug is covered. The other Drugs are called prerequisite Drugs. They are equally effective, have FDA approval and may cost less. They treat the same condition as the step therapy Drug. If You don't try the other Drugs first, You may need to pay full cost for the step therapy Drug. If Your doctor determines that a first-line Drug is not right for You, then Your Prescription Drug Benefit will cover second-line Drugs, which are often less-preferred and more expensive.

To request a Drug with step therapy requirements, You or Your doctor can contact the Prior Authorization Department at Capital Rx at 833-502-3346. For more information, You or Your doctor can call 833-502-3346. If MHHIC does not deny an Exception request before 72 hours, the request is considered granted. When the prescribing Provider believes that the denial of the request makes the death of or serious harm probable and MHHIC does not deny the request before 24 hours, the request is considered granted.

If You have questions about step therapy or Prior Authorization, please call Us at 855-645-8448, which is the Prior Authorization number on the back of Your MHHIC ID card.

For the Treatment of Stage Four Metastatic Cancer

Step therapy is not required for Prescription Drugs that are being used to treat stage four advanced metastatic cancer, as long as the Drugs are FDA-approved, and its use is consistent with best practices for the treatment of stage four advanced, metastatic cancer or an associated condition and supported by peer-reviewed, evidence-based literature.

For the Treatment of Serious Mental Illness

Covered Drugs when approved by United States Food and Drug Administration (FDA) and prescribed to treat Serious Mental Illness in Members aged 18 Years or older will not be subject to the following Step Therapy requirements:

- Failure to respond to more than one different Drug for each Drug prescribed, excluding the Generic or pharmaceutical equivalent of the prescribed Drug; or
- Proven history of failure of more than one different Drug for each Drug prescribed, excluding the Generic or pharmaceutical equivalent of the prescribed Drug.

If a Generic or pharmaceutical equivalent is added to the Plan's Formulary, a Plan may impose step therapy once in the Plan Year.

Prior Authorization For Autoimmune Diseases, Hemophilia, or Von Willebrand disease

Prior Authorization will not be required more than once annually for covered Drugs used to treat an autoimmune disease, hemophilia, or Von Willebrand disease, with the exception of:

- opioids, benzodiazepines, barbiturates, or carisoprodol;
- Prescription Drugs that have a typical treatment period of less than 12 months; and
- Drugs that:
  - have a boxed warning assigned by the United States Food and Drug Administration (FDA) for use; and
  - must have specific Provider assessment; or
- Prescription Drugs used in a manner other than the FDA approved use.

Prescription Drug Refill

Refills of a Prescription Drug will not be covered until the Member is reasonably due for a refill as calculated based upon the Prescription Drug being taken at the prescribed dosage and appropriate intervals.

For Prescription eye drops to treat a Chronic eye disease or condition, MHHIC allows the refill of Prescription eye drops if You timely pay at the point of sale the maximum amount allowed and:

- the original Prescription states that additional quantities of the eye drops are needed;
- the refill does not exceed the total quantity of dosage units Authorized by the prescribing Provider on the original Prescription, including refills; and
- the refill is dispensed on or before the last day of the prescribed dosage period and:
  - not earlier than the 21st day after the date a Prescription for a 30-day supply of eye drops is dispensed; or
  - not earlier than the 42nd day after the date a Prescription for a 60-day supply of eye drops is dispensed; or
  - not earlier than the 63rd day after the date a Prescription for a 90-day supply of eye drops is dispensed.

Oral Contraceptive Drugs

Your Plan provides for an enrollee to obtain:

- a three-month supply of a covered Prescription contraceptive Drug at one time the first time the enrollee obtains the Drug; and
- a 12-month supply of a covered Prescription contraceptive Drug at one time each subsequent time the enrollee obtains the same Drug.

Contraceptive Drugs are limited to only one 12-month supply during each 12-month period.

Medication Synchronization

Within the terms, conditions, Limitations and Exclusions of this Plan, You may qualify for Medication Synchronization for medications that are defined as Maintenance Drugs. Prescription Drugs will be considered for Medication Synchronization as follows:

- Meet Prior Authorization criteria (if any is noted on the Formulary).
- Used for treatment and management of Chronic illnesses or diseases.
- Must possess a valid Prescription that has refills.
- A formulation that can be effectively dispensed in accordance with the Medication Synchronization Plan.
- is not a Specialty Drug (unless enrolled in other programs like the Split Fill Program)
- Not a Schedule II or III controlled substance as defined by applicable laws or be a product that contains an opioid agent.
- May qualify for synchronizing refills and pro-rated Cost Sharing amounts for partial supplies of certain medications.

When a Member receives a partial supply of a Maintenance Drug, We will prorate any Cost Sharing amount charged if the Pharmacy or the Member's prescribing Physician notifies Us that:

- the quantity dispensed is to synchronize the dates that the Pharmacy dispenses the Member's Prescription Drugs.
- the synchronization of the dates is in the best interest of the Member; and
- the Member agrees to the synchronization.

The proration must be based on the number of days' supply of the Drug actually dispensed.

Typically, the amount You pay for a Prescription Drug covers a full month's supply of a Prescription Drug. However, You may receive a partial amount for the purpose of aligning the dates that Your Pharmacy dispenses Your Drugs. If so, You will not have to pay for the full month's supply for certain Drugs.

The amount You pay when You get less than a full month's supply will depend on whether You are responsible for paying a Copayment or a Member percentage:

- If You are responsible for a Copayment for the Drug, Your Copayment will be based on the number of days of the Drug that You receive. We will calculate the amount that You will pay per day for Your Drug and multiply it by the number of days of the Drug You receive.

  For example: If the Copayment for Your Drug for a full month's supply (a 30-day supply) is $30, the amount per day would be $1. If You receive a 7-day supply of the Drug, Your payment will be $1 per day multiplied by 7 days, for a total Copayment of $7.

- If You are responsible for a percentage, You pay the same percentage regardless of whether the Prescription is for a full month's supply or for fewer days. However, because the entire Drug cost will be lower if You get less than a full month's supply, the amount You pay will be less.

Please check the Plan Formulary and contact the health Plan for more information on Medication Synchronization or prorated Cost Shares.

Copayments and Other Cost Shares

A Member must pay the Copayment or Coinsurance for each Prescription Drug based on the quantity and days' supply dispensed as stated in the **SCHEDULE OF BENEFITS**. Any Deductible, and/or Copayments or Coinsurance for Prescription Drugs shall be considered Out-of-Pocket Expenses for purposes of meeting the Member's Out-of-Pocket Maximum. The amount a Member pays for a Prescription Drug will never exceed the lowest cost option among:

- the Copayment or Coinsurance, as stated in the **SCHEDULE OF BENEFITS**;
- the Usual and Customary Rate for the Prescription Drug; or
- the actual price of the Prescription Drug.

We will apply any third-party payment, financial assistance, discount, product voucher, or other reduction of Out-of-Pocket Expenses for a Covered Drug to the Member's Deductible, Copayment, Coinsurance, Cost Share, or Maximum Out-of-Pocket.

This only applies when:

- A Generic or interchangeable product does not exist; or
- A Generic or interchangeable product exists but the Member was approved by the health Plan to use the drug.

Our Drug Formulary includes one insulin from each therapeutic class. Cost Sharing for insulin that is on the Formulary will not exceed $25 per Prescription for a 30-day supply. Emergency refills of insulin and insulin-related equipment are covered in the same manner as non-emergency refills.

Direct Member Reimbursement

When Prescriptions are processed through the Member's Plan, there is a maximum contracted rate that can be charged by the Network Pharmacy. When requesting reimbursement for Medically Necessary and covered medications purchased Out-of-Pocket by the Member, reimbursement is calculated based on the Network Pharmacy's contracted rate less the Copayment or Coinsurance and Deductible amounts due. Medications for which reimbursement is requested must still adhere to any coverage restrictions.

Discontinuance of Prescription Drugs or Intravenous Infusions

We will provide notice of an Adverse Determination for a concurrent review of the provision of Prescription Drugs or intravenous infusions for which You are receiving Benefits under this Certificate of Coverage not later than the 30th day before the date on which the provision of Prescription Drugs or intravenous infusions will be discontinued.

Other Covered Services

Phenylketonuria or Heritable Metabolic Disease

Coverage for specialty dietary formulas necessary to treat Phenylketonuria or a Heritable Metabolic Disease are available to Members as prescribed by a licensed Provider. Coverage will be provided to the same extent that We provide coverage for Drugs that are Medically Necessary and on the orders of a Physician.

Amino Acid-Based Elemental Formulas

The Plan includes Benefits for Medically Necessary Amino Acid-Based Elemental Formulas as ordered by a licensed Provider. Amino acid-based elemental formulas coverage will be provided when Medically Necessary on a basis no less favorable than that on which Prescription Drugs and other medications and related services are covered by Us; and also, when prescribed by a Physician for the treatment of:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein-induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; or
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Oral Anticancer Medications

Prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Coverage is provided on a basis no less favorable than intravenously administered or injected cancer medications. Benefits for such medications are subject to the same Deductible or Copayment requirement as would apply to chemotherapy provided as Infusion Therapy.

Pharmacy Network

Network Retail Pharmacies

When a Member has a Prescription filled, they must present their ID Card. The Pharmacy will calculate the Copayment and Deductible responsibilities, if any. Members will not need to submit Claim forms but are responsible for paying applicable Deductible and Copayment amounts to the Pharmacy. Any applicable Deductible and/or Copayment are shown on the **SCHEDULE OF BENEFITS**.

For Self-Administered Injectable Drugs and syringes Members pay the Copayment rate shown on the **SCHEDULE OF BENEFITS** per 30-day supply per Prescription for Self-Administered Injectable Drugs, syringes and any combination kit or package containing both oral and Self-Administered Injectable Drugs, except insulin. No coverage is provided for a Prescription Drug from an Out-of-Network Pharmacy.

The direct link to the Pharmacy search/directory is: https://healthplan.memorialhermann.org/members/pharmacy-benefit-information.

Mail Order Program

Prescription Drugs may be purchased through the Costco Mail Order Pharmacy program, as indicated on the **SCHEDULE OF BENEFITS**. A maximum number of days' supply per Prescription and/or refill will be dispensed per order, shown on the **SCHEDULE OF BENEFITS**.

Please note that some Prescription Drugs and/or medications may not be available through the mail order program. Check with the mail order Pharmacy Customer Service Department for availability of the Drug or medication.

The Prescription must state the Drug name, dosage, directions for use, quantity, number of refills (if permitted), the

Physician's name and phone number, the patient's name and address, and be signed by a Physician. Submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. Members need only pay any applicable Deductible amount and the Copayment or Prescription Drug Deductible, if any. The first mail order Pharmacy Prescription must include a completed patient profile form.

- The direct link to the Costco mail order landing page (where You can navigate, set up and log in to Your account, etc.), is: https://www.costco.com/pharmacy/home-delivery.
- Call Costco Mail Order Pharmacy directly at 1-800-607-6861.
  Monday to Friday 7 a.m. to 9 p.m. CT and Saturday 11:30 a.m. to 4 p.m. CT, Closed on Sunday
- To get started or to download the mail order form, visit:
  https://www.costcohealthsolutions.com/pages/Members_MailOrder.aspx#.

Exceptions Requests and Appeals

An **Exception Request** is a request that We cover a Prescription Drug that is not on Your Prescription Drug Formulary. You, Your designee, or Your prescribing Physician (or other prescribing Provider) have the right to submit an Exception request to Us.

Standard Exception Request. Under a standard Exception request, We will make a determination and notify You, Your designee, and Your prescribing Physician (or other prescribing Provider) no later than 72-hours from receipt of Your request for review. If We grant Your Exception request and agree to cover the Non-Formulary Prescription Drug, the coverage will remain in place for the length of the Prescription, including any refills, as long as You remain enrolled under this Plan.

Expedited (Urgent) Exception Request. You, Your designee, Your prescribing Physician (or other prescriber) may request an expedited review of an Exception request based on exigent circumstances. Exigent circumstances exist when You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or when You are undergoing a current Course of Treatment using a Non-Formulary Prescription Drug. We will make a determination on an expedited review request and notify You or Your designee and Your prescribing Physician (or other prescriber) of the coverage determination no later than 24-hours following receipt of the request. If We grant an Exception based on Your exigent circumstances, the Non-Formulary Prescription Drug will be covered for the duration of Your exigent circumstances, as long as You remain enrolled in this Plan.

An **Expedited Exception Request** must include:

- information related to the existence of the exigency and a description of the harm that could reasonably occur to the Member if the requested Non-Formulary Drug is not provided in the 24-hour timeframe; and
- justification supporting the need for the Non-Formulary Drug to treat the Member's condition, including a statement that all covered Formulary Drugs, on any tier, will be or have been ineffective, are less effective, or would result in adverse effects.

External Appeals of Denied Exception Requests. If We deny either Your standard Exception request or Your expedited Exception request for coverage of a Non-Formulary Prescription Drug, You, Your designee, or Your prescribing Physician (or other prescriber) may request that Your Exception request and Our denial be reviewed by an independent, External Review Organization. The External Review Organization must make a determination on Your Exception request and notify You, Your designee, and Your prescribing Physician (or other prescriber) of their coverage determination no later than 72-hours from receipt of Your review request if the original request was a standard Exception request, and no later than 24-hours from receipt of the request if the original request was an expedited Exception request. If the External Review Organization approves the Non-Formulary Prescription Drug through the External Review process, coverage of the Drug will be for the same duration as described above under standard Exception request and under expedited Exception request.

The External Review Organization's information and Appeal process can be found on the denial letter or Adverse Determination letter You receive from the Pharmacy Benefit Manager (PBM), Capital Rx.

PREVENTIVE AND WELLNESS CARE

The following Wellness Care and Preventive Services are available to a Member upon the Effective Date required for the coverage. These services are provided for the purpose of promoting good health and early detection of disease.

If a Member receives Preventive or Wellness Covered Services from an in-network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge with no Deductible or Copayment. When Preventive or Wellness Care Covered Services are rendered by an Out-of-Network Provider, Benefits will be subject to Copayment amounts (if applicable) and Coinsurance percentages shown on the **SCHEDULE OF BENEFITS**. Also, if a Preventive service is provided during an Office Visit in which the Preventive service is not the primary purpose of the visit, a Copay or Coinsurance will still apply. The Deductible Amount will not apply to Covered Services received for Preventive or Wellness Care.

Well Woman Examinations

- One (1) routine annual visit per Benefit period to an obstetrician/gynecologist or Primary Care Provider. Additional visits recommended by the Member's obstetrician/gynecologist or Primary Care Provider may be subject to the Deductible amount, Copayment or Coinsurance percentage shown on the **SCHEDULE OF BENEFITS**, if not a Preventive service.
- One (1) routine pap smear, cervical and ovarian cancer screening per Benefit period for early detection including:
    - blood, laboratory, and Diagnostic Services in connection with evaluating the pap smear.
    - the Provider's charge for administration of the test, for any covered female 18 years of age or older, not to exceed one (1) every three (3) years, for:
        - a CA 125 blood test; and
        - a conventional pap smear screening, a screening using liquid-based cytology methods, or any other test or screening approved by the United States Food and Drug Administration (FDA), for the detection of human papillomavirus (HPV) and ovarian cancer.
- We cover mammograms for the screening of breast cancer as follows:
    - 2-D and all low-dose mammography including digital mammography and breast tomosynthesis (3-D mammography) annually for women aged 35 and over.
    - All screening mammograms are covered at no cost to You when obtained from a Network Provider. Film mammograms obtained from an Out-of-Network Provider will be subject to Coinsurance as shown in the **SCHEDULE OF BENEFITS**.
- Diagnostic imaging includes imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging. Diagnostic imaging is designed to evaluate an abnormality detected by a patient and to evaluate an individual with dense breast tissue. Diagnostic imaging is also designed to evaluate:
    - A subjective or objective abnormality detected by a Physician or patient in a breast;
    - An abnormality seen by a Physician on a screening mammogram;
    - An abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician.
- We cover diagnostic mammograms as follows:
    - 2-D and all low-dose mammography including digital mammography and breast tomosynthesis (3-D mammography). The 35-year and older age requirement does not apply to diagnostic imaging screenings.
    - All diagnostic mammograms are covered at no cost to You when obtained from a Network Provider. Film mammograms obtained from an Out-of-Network Provider will be subject to Coinsurance as shown on the **SCHEDULE OF BENEFITS**.

Annual well-woman Preventive Care visits are another opportunity for women to obtain the recommended adult Preventive Care services that are age and developmentally appropriate including:

- Preconception and prenatal care.
- Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- High-risk human papillomavirus DNA testing in women with normal cytology results, beginning at 30 years of age and occurring no more frequently than once every five (5) years.
- Annual counseling on sexually transmitted infections for all sexually active women.

- Annual screening and counseling for human immune-deficiency virus infection for all sexually active women.
- Prescription FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, including injectable Drugs and implants, intra-uterine devices, diaphragms, and the Professional Services associated with them.
- Comprehensive lactation support and counseling by a trained Provider during pregnancy and/or in the postpartum period and rental and Preauthorization required for purchase of breastfeeding equipment not to exceed $500; and
- Annual screening and counseling for women for interpersonal and domestic violence.

Preventive Care and screenings provided for women are supported by the U.S. Health Resources and Services Administration and performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists, the U.S. Preventive Services Task Force (USPSTF), or another similar national organization of medical professionals recognized by the insurance commissioner.

Physical Examinations and Testing

Routine Wellness Physical Exam

You are eligible for a physical examination once every Certificate of Coverage year. Eye and ear examinations for Children are covered through age 17 years, to determine the need for vision and hearing correction complying with established medical guidelines. Coverage is also available for one annual hearing screening for Members between the ages of 18 and 21 years; and one annual vision screening (risk assessment) up through the age of 21 years. Vision screens do not include refractions.

Certain routine Wellness diagnostic tests ordered by Your Physician are covered. Examples of routine Wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol, and blood sugar levels.

Adult Immunizations

MHHIC will cover adult Immunizations rated as “A” or “B” by the United States Preventive Services Task Force (USPSTF) and recommended by the Advisory Committee on Immunization Practices (ACIP) and supported by the Health Resources, Services Administration (HRSA) and the Centers for Disease Control and Prevention.

Child Immunizations

MHHIC covers Immunizations for Children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Coverage for Child Members from birth through the date of the Child's sixth (6th) birthday includes Immunization against: diphtheria, haemophilus influenza type b, hepatitis, measles, mumps, pertussis, polio, rubella, tetanus, varicella, rotavirus, and any other Immunization that is required for the Child by law.

This Benefit is not subject to Copayments, Deductibles or Coinsurances when provided by Network or Out-of-Network Providers in accordance with the recommendations of ACIP.

Well Baby & Well Child Care

Well Baby Care routine examinations will be covered for infants under the age of 24 months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the routine Wellness physical exam Benefit.

Prostate Cancer Screening

One (1) physical rectal exam and one (1) prostate-specific antigen (PSA) test per Benefit period, is covered for Members fifty (50) years of age or older and asymptomatic or if the Member is over forty (40) years of age with a Family history of prostate cancer or another prostate cancer risk factor. A second visit will be permitted if recommended by the Member’s Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

Aortic Aneurysm Screening

A one-time screening for an abdominal aortic aneurysm (AAA) with ultrasonography is covered for men aged 65 to 75 years who have a history of smoking.

Cardiovascular Screening

Screening for cardiovascular disease, including atherosclerosis and abnormal artery structure, every 5 years for a male older than 45 years of age or a female older than 55 years of age, who is diabetic or has an intermediate or higher risk for developing coronary heart disease (based on a score derived using the Framingham Heart Study coronary prediction algorithm). Routine screening for low-risk patients is not covered.

Colorectal Cancer Screening

Colorectal cancer exams, Preventive services, and lab tests with an "A" or "B" grade from the United States Preventive Services Taskforce (USPSTF) are covered for Members starting at age 45 years. A follow-up colonoscopy is also covered if the results of the initial colonoscopy, test, or procedure were abnormal.

Selected Generic Physician-prescribed colonoscopy preparation and supplies for colonoscopies covered under the Preventive and Wellness Benefit will be covered at first dollar when obtained from a Network Pharmacy. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Member only under the following circumstances: Physician prescribes brand-name colonoscopy preparation and supplies because of Member's inability to tolerate selected Generic colonoscopy preparation and supplies.

Lung Cancer Screening

A lung cancer screening is covered for adults aged 60 to 80 years who have a 20 pack per year smoking history and currently smoke or have quit within the past 15 years. The covered screening is performed with a low dose computed tomography (CT) every year. Screenings are discontinued once a person has not smoked for 15 years or has a health problem that limits life expectancy or the ability to have lung Surgery.

Nicotine Dependence Treatment

Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence. MHHIC's various nicotine treatment options are noted in Our 2026 Formulary.

Bone Mass Measurement

Scientifically proven tests for the diagnosis and treatment of osteoporosis if a Member is:

- a woman 65 years or older or postmenopausal who is not receiving estrogen replacement therapy; or
- an individual with vertebral abnormalities; primary hyperparathyroidism; or has a history of bone fractures; or
- receiving long-term glucocorticoid therapy; or
- being monitored to assess the response to or efficacy of an approved osteoporosis Drug therapy.

Services recommended by the U.S. Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

The list of covered Preventive and Wellness Care Services changes from time to time. To check the current list of recommended Preventive or Wellness Care Services for adults and Children required by the Patient Protection and Affordable Care Act (PPACA), visit the U.S. Department of Health and Human Services' website at https://healthcare.gov/preventive-care-benefits/.

CLAIMS PROVISIONS

How to File a Claim for Benefits

MHHIC and our Providers have entered into agreements that eliminate the need for a Member to personally file a Claim for Benefits. Network Providers will file Claims for Members either by mail or electronically.

Prescription Drug Claims

Most Members will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically when You present Your ID card to a Network Pharmacy. However, if You must file a Claim to access Your Prescription Drug Benefit, You must use the Prescription Drug Claim form.

The Prescription Drug Claim form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit manager, whose telephone number should be found on Your ID card. Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug. A Commercial Member Reimbursement Drug Claim Form can be found by visiting: https://healthplan.memorialhermann.org/members/commercial-pharmacy-benefits-and-services/pharmacy-network.

Other Medical Claims

When You receive other medical services (clinics, Provider offices, etc.) You should ask if the Provider is a Network Provider. If yes, this Provider will file Your Claim with Us. In some situations, the Providers may request payment and ask You to file. If this occurs, be sure the Claim form is complete before forwarding to MHHIC. If You are filing the Claim, the Claim must contain the itemized charges for each procedure or service. Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills.

Itemized bills submitted with Claim forms must include the following:

- Full name of patient
- Date(s) of service
- Description of and procedure code for service
- Diagnosis code
- Charge for service
- Name and address of Provider of service

Claims for Durable Medical Equipment (DME)

DME Claims are processed like other medical Claims, may be subject to review for Medical Necessity and will be processed at the allowable rate. For processing charges on the rental, purchase, and necessary repairs/maintenance of wheelchairs, braces, crutches, etc., the invoice from the supplying Provider must include:

- a description of the item rented, purchased, or serviced, and
- the date, charge, and patient's name.

A statement from the attending Physician or allied health Provider that services were Medically Necessary may also need to be filed with these bills.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. All Durable Medical Equipment used in Infusion Therapy will be excluded under this Certificate of Coverage except where specifically stated under the Benefit for Infusion Therapy.

Claims Questions

Your Claim(s) will be processed according to the terms of this Certificate of Coverage, in the time frames required by law. Members may write Us at the Claims address noted on the “Contact Information” page at the beginning of this Certificate of Coverage or call Our Customer Service Department at 855-645-8448. For Prescription Drug Claims information, call Our Customer Service Department at 833-502-3346.

Payment of Claims

Payment to You, Your beneficiary, or Your estate: Benefits will be paid to You, unless assigned as outlined below. Any unassigned Benefits that are unpaid at Your death will be paid either to the beneficiary or to Your estate if no

beneficiary is named. If Benefits are payable to Your estate or to You or to a beneficiary who cannot execute a valid release, We may pay Benefits up to $1,000 to someone related to You or a beneficiary by blood or marriage whom We deem to be equitably entitled to such Benefits. We will be discharged to the extent of any such payments made by Us in good faith.

Assignment of Claim payments: We will recognize any assignment made under the Certificate of Coverage, if:
- it is duly executed on a form acceptable to Us;
- a copy is on file with Us; and
- it is made by a Provider licensed and practicing within the United States.

We assume no responsibility for the validity or effect of an assignment. Payment for services provided by a Network Provider is automatically assigned to the Provider. The Network Provider is responsible for filing the Claim and We will make prompt payments to the Provider for any Benefits payable under this Certificate of Coverage. Payment for services provided by a Out-of-Network Provider are payable to You unless assignment is made as above. Out-of-Network Providers are not required to file a Claim on Your behalf, but they may do so, if they choose.

Payment to a Possessory or Managing Conservator

Benefits paid on behalf of a covered Dependent Child may be paid to a person who is not the Subscriber. The Subscriber can also be paid Benefits if an order is issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the Child.

To be entitled to receive Benefits, a possessory or managing conservator of a Child must submit to Us with the Claim form, written notice that such person is the possessory or managing conservator of the Child on whose behalf the Claim is made and submit a certified copy of a court order establishing the person as possessory or managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of Benefits has been exercised or to Claims submitted by the Subscriber where the Subscriber has paid any portion of a medical bill that would be covered under the terms of the Certificate of Coverage.

Claims Provisions

A claimant's right to make a Claim for any Benefits provided by this Certificate of Coverage is governed as follows:

- **Notice of Loss**
  A claimant should send a written Notice of Loss to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Certificate of Coverage holder. When We receive the notice, We will send a proof of Claim form to the claimant. The claimant should receive the proof of Claim form within 15 days of the date We received the notice of Claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so.

- **Proof of Loss**
  In the case of a Claim for a loss, written proof of the loss must be provided to Us not later than the 95th day after the date of the loss. Failure to provide written proof of a loss within the time prescribed does not validate or reduce a Claim if:
    - it was not reasonably possible to provide written proof of the loss within that time;
    - written proof of the loss is provided as soon as reasonably possible; and
    - unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required.

  When You file proof of loss, You may direct Us, in writing, to pay health care Benefits to the recognized Provider of health care who provided the Covered Service for which Benefits became payable. For Covered Services, We will determine to pay either the Covered Person or the facility or the practitioner.

- **Payment of Claims**
  All Benefits payable under the Certificate of Coverage, must be paid not later than the 30th day after the date the proof of loss is received.

In the event of a weather-related catastrophe or major natural disaster, as defined by the commissioner, the Claim-handling deadlines imposed are extended for an additional 15 days.

If You have any questions about any of the information in this section, You may call Our Customer Service Department at (855) 645-8448.

Legal Actions

You cannot sue on any Claim before 60 days after written proof of loss has been given as required. You cannot sue on any Claim after three (3) years from the time written proof of loss is required to be given.

If You call for information about a Claim, We can better help You if You have the Certificate of Coverage number, patient's name, and date of service readily available.

Request a Credit toward Your PPO Deductible and Annual Out-of-Pocket Maximum Expenses

In accordance with Texas Insurance Code §1301.140 (HB2002) (a) An insurer shall credit toward an insured's Deductible and annual Out-of-Pocket Maximum expenses an amount the insured pays directly to any Physician or healthcare Provider for a Medically Necessary covered medical or healthcare service or supply if a Claim for the service or supply is not submitted to the insurer and the amount paid by the insured to the Physician or healthcare Provider is less than the average discounted rate for the service or supply paid to an equivalently licensed or authorized Network Provider under the insured's Network Provider (PPO) Benefit Plan.

If You are a PPO Member and made a cash payment for Covered Services You received by an Out-of-Network Provider or a Network Provider instead of filing a Claim with Your insurance, You are entitled to receive credit toward Your Deductible and/or Out-of-Pocket Maximum up to the Allowable Amount. You will need to submit a PPO Member Out-of-Pocket Expense Credit Form to:

Memorial Hermann Health Plan
ATTN: Claims Department – Member Responsibility Credit
P.O. Box 20167
Tampa, FL 33622-0167

You can find the PPO Member Out-of-Pocket Expense Credit Form posted on the Memorial Hermann Health Plan website at https://healthplan.memorialhermann.org/members/resource-center. Your request for Deductible and/or Out-of-Pocket Maximum credit must be submitted (postmarked) within 95 days of the date services were provided. When we receive Your request for credit, We will contact You if additional information is needed.

Your request will be reviewed to determine that the services provided on Your Claim are covered by Your Plan. If covered, and the Claim has not previously been submitted (by You or Your Provider), then a credit for Your payment amount will be applied to Your Deductible and/or Out-of-Pocket Maximum, up to the allowable that would have been paid to the Provider.

UTILIZATION REVIEW PROCEDURE AND REVIEW PROGRAMS

This Certificate of Coverage includes a program to evaluate Inpatient and Outpatient Hospital and Ambulatory Surgical Center Admissions, and specified non-Emergency Outpatient Surgeries and diagnostic procedures and other services, if indicated on the **SCHEDULE OF BENEFITS**. This program ensures that Hospital and Ambulatory Surgical Facility care is received in the most appropriate setting, and that any other specified Surgery or service are Medically Necessary. This program is known as Utilization Review.

Utilization Review is not a guarantee of coverage. Payment of Benefits will be determined by the terms, conditions, Exclusions, and Limitations of Your Certificate of Coverage. Payment for a Claim will only be denied or reduced if the Physician or Provider has materially misrepresented the proposed services or has substantially failed to perform the Preauthorized services. No Benefits are payable unless the Member's coverage is in force at the time services are rendered.

Approval will be provided only when:

- the services are Medically Necessary as determined by Us;
- the services are not Experimental and Investigational; and
- the services are determined by Us to be eligible under this Certificate of Coverage.

Utilization Review may be undertaken:

- at least three (3) calendar days before a non-emergency Hospital or Ambulatory Surgical Center Admission or any of the specified services, if specified on the **SCHEDULE OF BENEFITS**. This is known as Preauthorization (see below).
- before a Hospital or Ambulatory Surgical Center Admission or any of the specified services, if specified on the **SCHEDULE OF BENEFITS**. This is known as Preadmission review (see below).
- during a Hospital stay. This is known as continued stay review (see below).
- following discharge from a Hospital or an Ambulatory Surgical Center or after any of the specified services are performed, if specified on the **SCHEDULE OF BENEFITS**, or when a Claim for Benefits is made. This is known as a retrospective review (see below).

If We determine that a Hospital stay or any Surgery or any other service is not Medically Necessary, You may be responsible for payment of the charges for those services.

Preauthorization Process and Time Frames

Preauthorization

Your Physician will initiate Preauthorization by calling MHHIC at 855-645-8448 as far in advance as possible, but no later than three (3) calendar days prior to the scheduled date of any proposed service requiring Preauthorization. If MHHIC determines that the service is not Medically Necessary or Experimental or Investigational, You and Your Physician will be notified of Our determination in writing within three (3) calendar days after the requested Preauthorization.

- Preauthorization may not be required for particular health care services if Your Physician or Provider meets criteria for exemption from Preauthorization of one or more of those health care services under applicable law.

If the proposed health care service involves Inpatient care, such as a planned procedure which would require Preauthorization, We will review the request and issue a length of stay for the elective Admission into a health care facility based on the recommendation of Your Physician or Provider and Our written medically accepted screening criteria and review procedures. If You are urgently or emergently Hospitalized and require a continued stay in the Hospital,, We will review the request and issue a determination indicating whether the continuation of services are appropriate within 24 hours of receipt of the request from the Physician or Provider.

If the proposed medical care or health care services involve post-stabilization treatment, or a Life-Threatening condition, We will issue and transmit a determination indicating whether proposed services are Preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no case to exceed one (1) hour from receipt of the request. The determination will be provided to the Provider of record. If We issue an Adverse Determination in response to a request for post-stabilization treatment or a request

for treatment involving a Life-Threatening condition, We will provide to the Member or individual acting on behalf of the Member, and the Member's Provider of record, a written notification regarding the Adverse Determination.

Preauthorization is required for charges incurred in connection with:

- Inpatient Services (except if admitted due to an Emergency)
- Mental Health & Substance Abuse Outpatient Services - MH/SA intensive (extended) or residential services, Applied Behavioral Analysis (ABA) therapy and non-behavioral health Providers neuropsychiatric testing
- Non-Emergency Outpatient Surgeries & Diagnostic Procedures
- ABA in Cognitive Therapy
- Skilled Nursing Facility Admission
- Durable Medical Equipment of $500 or more
- Out-of-network services for hearing aids
- Cochlear Implants
- Genetic testing
- Hospice Care
- Certain Prescription Drugs including Specialty Drugs and certain injectable Drugs
- Services and/or Prescription Drugs to enhance fertility
- Complex imaging services
- Home Health Care
- Prosthetics and Orthotic Devices

For a complete list of services that require Preauthorization, see Our website at: https://healthplan.memorialhermann.org/for-providers/resource-center, scroll down to the Medical Management topic and click on '2026 Medical Management Preauthorization List.'

Subject to the notice requirements and prior to the issuance of an Adverse Determination, if We question the Medical Necessity, appropriateness, or Experimental or Investigational nature of a service, We will give the Physician who ordered it a reasonable opportunity to discuss Your treatment plan with Our Physician and inform them of the clinical basis for Our determination. You and Your Physician will be sent a written notice within three (3) calendar days of the receipt of the request. The written notice will include: the principal reasons for the Adverse Determination; the clinical basis for the Adverse Determination; a description of the source of the screening criteria used as guidelines in making the Adverse Determination; the professional specialty of the Physician, doctor, or other health care Provider that made the Adverse Determination; a description of the Complaint and Appeal process; a copy of the request for a review by an External Review Organization form; and notice of the External Review process with instructions. If You have a Life-Threatening condition or if We are denying the provision of Prescription Drugs or intravenous infusions for which You are receiving Benefits under this Certificate of Coverage, the notice will include a description of Your right to an immediate review by an External Review Organization and the procedures to obtain that review. If We discontinue the provision of Prescription Drugs or intravenous infusion, You will receive the notice no later than the 30th day before the date on which the provision of Prescription Drugs or intravenous infusions will be discontinued.

For an Emergency Admission or procedure, We must be notified within 48 hours of the Admission or procedure or as soon as reasonably possible. We may consider whether Your condition was severe enough to prevent You from notifying Us, or whether a member of Your Family was unable to notify Us for You.

There are penalties for some services if Preauthorization is not performed as outlined on the **SCHEDULE OF BENEFITS**. Note: These penalties are not counted toward the Deductible, Prescription Drug Deductible, if any, or Your Out-of-Pocket Maximum.

Non-Urgent Preauthorization

When You submit a request for services not associated with post-stabilization treatment, Life-Threatening condition, or concurrent Hospitalization care, a determination will be issued and transmitted not later than the third calendar day after the date the request is received by MHHIC.

Concurrent Hospitalization care Authorization determinations will be issued no later than 24 hours after the request is received by MHHIC.

Preauthorization Renewal Process

Your Physician or other health care Provider may request a renewal of an existing Preauthorization at least 60 days before it expires. We must issue a determination, if possible, before the existing Preauthorization expires.

Preadmission Review

If Preauthorization is not performed before an elective or planned Hospital Admission, We may decline to make an initial determination of Medical Necessity. The Provider may then submit their Claims associated with the services provided and follow the post service Appeal process and explain why a Preauthorization request was not or could not be submitted prior to rendering the services.

Concurrent Care Review

Request for Approval of Additional Benefits

If a Member is undergoing a Course of Treatment for an Illness or Injury for which MHHIC has approved Benefits, and their Provider would like to request an approval of Benefits for additional treatments (extension of Benefits):

- Request the additional Benefits at least 24 hours prior to the end of the initially prescribed and approved Course of Treatment.
- If the Provider requests an extension of Benefits less than 24 hours prior to the end of the initially prescribed and previously approved Course of Treatment, depending on the Benefits, the request will be handled as if it were a new request for Benefits, rather than an extension of Benefits.
- If MHHIC receives a request for additional Benefits at least 24 hours prior to the end of the initially prescribed and previously approved Course of Treatment, We must notify the Member and the requesting Provider of Our decision regarding the request within 24 hours of receipt of the request, if the request is for Urgent Care Benefits.
- If MHHIC denies a request for additional Benefits, in whole or in part, We must explain the reason for the Adverse Benefit Decision and the Certificate of Coverage provisions upon which the decision was based no later than the third calendar day after the date the request is received.
- Members may appeal the Adverse Benefit Decision according to the rules for an Appeal of an urgent, preadmission or concurrent care Benefit decision, depending on the circumstances, within thirty (30) calendar days of the Adverse Benefit Decision.

Reduction or End of Benefits

If after approving a request for Benefits in connection with a Member's Illness, Injury, disease or other condition, MHHIC decides to reduce or end these Benefits, in whole or in part:

- MHHIC must notify You sufficiently in advance of the reduction in, or end of Benefits to allow a Member the opportunity to Appeal that decision before the reduction in, or end of, Benefits occurs. The notice will explain the reason for reducing or ending Benefits and the Certificate of Coverage provisions upon which the decision was made.
- To keep the Benefits MHHIC has already approved, a Member must successfully Appeal MHHIC's decision to reduce or end those Benefits. A Member must Appeal to MHHIC at least 24 hours prior to the reduction in, or end of, Benefits.
- If a Member Appeals the decision to reduce or end Benefits less than 24 hours prior to the reduction in, or end of, Benefits, the Appeal will be treated as if the Member was Appealing an Urgent Care Adverse Benefit Decision.
- If MHHIC receives an Appeal for Benefits at least 24 hours prior to the reduction in, or end of, Benefits, We must notify the Member of Our decision regarding the Appeal within 24 hours of receipt of the Appeal. If MHHIC denies an Appeal of the decision to reduce or end the Member's Benefits, in whole or in part, We must explain the reason for the adverse Benefit decision and the Certificate of Coverage provisions upon which the decision was based.
- Members may further Appeal the Adverse Benefit Decision according to the rules for Appeal of an Urgent Care Adverse Benefit Decision.
- MHHIC may not deny or reduce payment to a Physician or Provider for previously Preauthorized Benefits based on Medical Necessity, appropriateness of care, Experimental, or Investigational nature, unless the Physician or Provider has materially misrepresented the proposed services or has failed to perform the proposed services.

Continued Stay Review

We also will determine if a continued Hospital or Skilled Nursing Facility stay is Medically Necessary. We will provide notice of Our determination within 24 hours by either telephone or electronic transmission to the Provider of record, followed by written notice within three (3) working days to the Member and the Provider of record. If We are approving or denying post-stabilization care subsequent to Emergency treatment, or care related to a Life-Threatening condition, We will notify the treating Physician or other Provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one (1) hour after the request for approval is made. If MHHIC issues an Adverse Determination in response to a request for post-stabilization treatment or a request for treatment involving a Life-Threatening condition, MHHIC will provide the Member, and the Member's Provider of record, notification relating to External Review of Adverse Determinations.

Retrospective Review

If neither Preauthorization, nor preadmission review nor continued stay review was performed, We will use retrospective review to determine if a scheduled or Emergency service was Medically Necessary. In the event services are determined to be Medically Necessary, Benefits will be provided as described in the Certificate of Coverage. We will provide notice of Our Adverse Determination in writing to the Member and the Provider of record within a reasonable period, but not later than 30 days after the date on which the request or Claim is received, provided We may extend the 30-day period for up to 15 more days if:

- We determine that an extension is necessary due to matters beyond Our control; and
- We notify the Member and the Provider of record, within the initial 30-day period, of the circumstances requiring the extension and the date by which We expect to make a determination.

If the period is extended because of the Member's failure or the failure of the Provider of record to submit the information necessary to make the determination, the period for making the determination is tolled from the date We send Our notice of the extension to the Member or the Provider until the earlier of:

- the date the Member or the Provider responds to Our request; or
- the date by which the specified information was to have been submitted.

COMPLAINTS AND APPEALS

Complaints

MHHIC wants to know when a Member is unhappy about the care or services received from one of our Providers. If a Member wants to register a Complaint about Us or a Provider, please refer to the procedures below.

A Complaint is an oral or written expression of dissatisfaction with Us or with a Provider’s services. Members may call Customer Service to register a Complaint. Complaints apply to any issue not relating to a Medical Necessity or, Experimental or Investigational determination by Us. Complaints may concern contractual Benefit or Referral denials, or issues or concerns You have regarding Our administrative policies or access to Providers.

To file a Complaint regarding Your Medical services, please contact Us at:

Memorial Hermann Health Insurance Company
Attn: Medical Appeals & Grievances
P.O. Box 19909
Houston, TX 77224-1909
Customer Service: 855-645-8448

To file a Complaint regarding Your Prescription services, please contact Us at:

Capital Rx
c/o Memorial Hermann Health Plan
9450 SW Gemini Dr. # 87234
Beaverton, OR 97008
Phone Number: 833-502-3346
Hours of Operation: 24/7/365

A letter will be sent within five (5) business days acknowledging the date of receipt of the Complaint. A response will be mailed to the Member within thirty (30) calendar days. MHHIC will investigate and resolve a Complaint concerning an Emergency or a denial of continued Hospitalization:

- in accordance with the medical or dental immediacy of the case; and
- not later than one (1) business day after We receive the Complaint.

Appeal of Complaint Resolution.

A Member who is not satisfied with the resolution of the Complaint has the right to file a written request for an Appeal. We will send an acknowledgment letter to the Member no later than five (5) business days after the date the written request for Appeal is received. The Member has a right to appear in person before a Complaint Appeal panel at the site at which the Member normally receives health care services or at another site agreed to by the Member, or the Member may address a written Appeal to the Complaint Appeals panel. We will complete this Appeals process no later than thirty (30) calendar days after the date the written request for Appeal is received.

An Appeal of a Complaint relating to an ongoing Emergency or denial of continued Hospitalization shall be concluded in accordance with the medical or dental immediacy of the case and no later than one (1) business day after the Member's request for Appeal is received. At the request of the Member, We will provide, instead of a Complaint Appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or a similar specialty as the Physician or Provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the Appeal.

Adverse Determination Process and Time Frames

Adverse Determination

Our determination that treatment or services the Member requested or received are not Medically Necessary or appropriate or are Experimental or Investigational, based on Our Utilization Review standards is an "Adverse Determination," which means that the Member’s request for coverage of the treatment or services is denied. A Member, person acting on the Member's behalf, or the Member's Physician or other health care Provider, has the right to Appeal the Adverse Determination to Us orally or in writing in accordance with Our internal Appeal

procedures. If a Member, person acting on the Member's behalf; or the Member's Physician or other health care Provider, notifies Us orally, We will send a one-page form to the individual to use for making a written Appeal.

We will provide notice of an Adverse Determination as follows:

(1) with respect to a patient who is Hospitalized at the time of the Adverse Determination, within one (1) working day by either telephone or electronic transmission to the Provider of record, followed by a letter within three (3) working days notifying the patient and the Provider of record of the Adverse Determination;
(2) with respect to a patient who is not Hospitalized at the time of the Adverse Determination, within three (3) working days in writing to the Provider of record and the patient; or
(3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post-stabilization care subsequent to Emergency treatment as requested by a treating Physician or other health care Provider, the agent shall provide the notice to the treating Physician or other health care Provider not later than one (1) hour after the time of the request.

We will provide notice of an Adverse Determination for a concurrent review of the provision of Prescription Drugs or intravenous infusions for which You are receiving Benefits under this Certificate of Coverage not later than the 30th day before the date on which the provision of Prescription Drugs or intravenous infusions will be discontinued.

Appeals of Adverse Determinations

- We define an Appeal as a request from a Member or authorized representative to change an Adverse Determination made by Us. Note: Multiple requests to Appeal the same Adverse Determination will not be considered at any level of review.
- If a Member is not satisfied with Our Adverse Determination, an Appeal must be submitted orally or in writing within 180 days following receipt of the initial Adverse Determination.
- If the Member has questions or needs assistance putting the Appeal in writing, the Member may call Our Customer Service Department at 855-645-8448.
- The Member has the right to appoint an authorized representative to speak on their behalf in their Appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an internal or External Review of a denial. The authorized representative may be the Member's treating Provider.

In addition to the Appeal rights, the Member's Provider is given an opportunity to speak with a Medical Director for an informal reconsideration of Our Adverse Determination. The Member is encouraged to provide Us with all available information to help Us completely evaluate the Member's Appeal.

There are three (3) methods for initiating a Medical internal Appeal:
- Verbally: Call Customer Service at 855-645-8448
- By fax: 832-532-6373
- In Writing: Any pertinent clinical information to substantiate the case should be forwarded with the Appeal letter to:

Memorial Hermann Health Insurance Company
Attn: Medical Appeals and Grievance Department
P.O. Box 19909
Houston, TX 77224-1909

For initiating a Prescription internal Appeal:
- Verbally: Call 833-502-3346
- In Writing:

Capital Rx
c/o Memorial Hermann Health Plan
Attn: Prescription Appeals & Grievances
9450 SW Gemini Dr. #87234
Beaverton, OR 97008

Hours: Monday – Friday: 6 a.m. – 7 p.m. CST , Saturday – Sunday: 7 a.m. – 4 p.m. CST, and Major Holidays: 7 a.m. – 4 p.m. CST.

All written Appeals should include the following elements, when applicable:

- Member's name and identification number.
- The date of service, health care Provider, Claim amount (if applicable).
- The reasons for the Appeal, including an explanation why You think the denial was incorrect.
- Any supporting documentation to support Your written request such as medical records.

Please review Your "Complaint Rights" and "Appeal Rights" as presented with Your Certificate of Coverage documents. Upon request by the Member and free of charge, We will provide reasonable access to and copies of all documents, records, and other information relevant to the Member's Appeal.

Within five (5) working days of receipt of a written request, We will acknowledge a request and advise if We need additional documents to consider the Appeal. We will provide Our decision no later than thirty (30) days after the later of the date We receive the Appeal or the date the Member provides any additional information We request in order to consider the Appeal. If Your Appeal is denied, Our notice will include a clean and concise statement of the clinical basis for the denial and Your right to seek review of the denial from an External Review Organization and the procedures for obtaining that review.

Persons not involved in the previous decisions regarding the Member's Appeal will decide all Appeals. A Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the Member's Appeal, will review Medical Necessity Appeals. A Member must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an External Review Organization, except for Adverse Determinations involving denial of Prescription Drugs, intravenous infusions or Life-Threatening circumstances. The internal Appeal process is also deemed to be exhausted, allowing the Member to request an External Appeal without completing the internal Appeal process, if We fail to strictly comply with all requirements of the internal Appeal process, except in cases where Our non-compliance was de minimus, or minimal.

Specialty Appeals. If not later than the 10th working day after the date an Appeal is denied the Member's health care Provider requests a particular type of specialty Provider review the case, a health care Provider who is of the same or a similar specialty as the health care Provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review will review the decision denying the Appeal. The specialty review must be completed within 15 working days of the date the health care Provider's request for specialty review is received. Notification of the Appeal under this paragraph must be in writing.

For Drug step therapy, a standard Appeal based on medical or dental immediacy may not exceed 24 hours.

Expedited Appeals. For Expedited Appeals for Emergency care denials, denials of care for Life-Threatening conditions, denials of continued stays for Hospitalized Members and denials for the provision of Prescription Drugs or intravenous infusions for which You are receiving Benefits under this Certificate of Coverage:

- The Appeal will include a review by a health care Provider who has not previously reviewed the case and who is of the same or a similar specialty as the health care Provider that typically manages the medical condition, procedure, or treatment under review;
- An Expedited Appeal, with the exception of Drug step therapy Appeals, will be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one business day or 24-hours from the date all information necessary to complete the Appeal is received; and
- Notice of the internal review decision, with respect to an internal Expedited Appeal shall be provided by Us no later than 72 hours after We receive the request for an Expedited Appeal. Such notice may be provided by telephone or electronic transmission, but must also be followed with a letter.
- For Drug step therapy and Non-Formulary requests, an Expedited Appeal will be completed based on the medical or dental immediacy not to exceed 24 hours of the request.

If You have a Life-Threatening condition, or have been denied the provision of Prescription Drugs, denial of a Drug step therapy Exception or intravenous infusions for which You are receiving Benefits under this Certificate of Coverage, You have the right to an immediate review by an External Review Organization and You are not required to first request an internal review by Us.

External Appeals by the External Review Organization

If, You (or Your health care Provider, with Your consent) are dissatisfied with the results of the internal Appeal process, You (or Your health care Provider, with Your consent) have the right to pursue Your Appeal to an External Review Organization after receipt of the internal Appeal decision. External Appeals are also available for review of Our decision to rescind Your coverage under the Policy.

To initiate an External Appeal, You (or Your health care Provider, with Your consent) may, within four (4) months from receipt of the internal Appeal decision or from receipt of an Adverse Determination, file a request to review by the federally contracted External Review Organization, Maximus. Maximus does not have any affiliation with Us, Your health care Provider, or the Utilization Review agents. To request an External Appeal, fill out a federal review request form and return to:

HHS Federal External Review Request
Maximus Federal Services
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax: 1-888-866-6190

The preferred method of submission for External Review requests is the website portal, which can be accessed at https://externalappeal.cms.gov/ferpportal/#/home under the 'Request a Review Online' heading. If You need help obtaining the federal review request form, contact Customer Service at 855-645-8448.

The Maximus Federal Services examiner will contact Us upon receipt of the request for External Review. For a standard External Review, We will provide the examiner all documents and information used to make the final internal Adverse Benefit Determination within three (3) business days. For an Expedited External Review, We will provide the examiner all documents and information used to make the final internal Adverse Benefit Determination as soon as possible.

The Maximus examiner will give You and Us written notice of the final External Review decision as soon as possible, but no later than 20 days after the examiner receives the request for a standard External Review. For an Expedited External Review, the examiner will give You and Us the External Review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request.

We will pay for the External Review and We will comply with the External Review determination regarding the Medical Necessity or appropriateness of the treatment or services or the Experimental or Investigational nature of such treatment or services.

For Prescription External Review, please refer to the denial letter from the reviewing agent (Pharmacy Benefit Manager) for more information regarding how to proceed with requesting an External Review.

MEDICAL EXCLUSIONS AND LIMITATIONS

The Benefits as described in this Certificate of Coverage are not available for any services, complications from services, treatment or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a Sickness, Injury, condition, disease, or bodily malfunction. MHHIC will not pay for charges incurred for or in connection with:

- The amount of any charge which is greater than the Allowed Charge, except as otherwise provided for in this Certificate of Coverage.
- Services for Ambulance for transportation from a Hospital or other health care facility, unless the Covered Person is being transferred to another Inpatient health care facility.
- Blood or blood plasma which is replaced by or for a Covered Person. This Exclusion does not apply to the required coverage of whole blood and blood including the cost of blood, blood plasma, and blood plasma expanders.
- Services or supplies for which the Provider has not obtained a certificate of need, or such other approvals as required by law.
- Care and or treatment by a Christian science practitioner.
- Completion of Claim forms.
- Services or supplies related to Cosmetic Surgery except as otherwise stated in this Certificate of Coverage; complications of Cosmetic Surgery; Drugs prescribed for cosmetic purposes.
- Services related to custodial or domiciliary care.
- Dental Care or treatment, including appliances and dental implants, except as otherwise stated in this Certificate of Coverage.
- Services or supplies, the primary purpose of which is educational providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for behavior problems or learning disabilities except as otherwise stated in this Certificate of Coverage.
- Experimental or Investigational treatments, procedures, Hospitalizations, Drugs, biological products, or medical devices, except as otherwise stated in this Certificate of Coverage.
- Extraction of teeth, except as otherwise stated in this Certificate of Coverage.
- Services or supplies for or in connection with:
  - Except as otherwise stated in this Certificate of Coverage for Covered Persons through the end of the month in which he or she turns age 19 years, exams to determine the need for (or changes of) eyeglasses or lenses of any type;
  - Except as otherwise stated in this Certificate of Coverage for Covered Persons through the end of the month in which he or she turns age 19 years eyeglasses or lenses of any type; this Exclusion does not apply to initial replacements for loss of the natural lens; or
  - Eye Surgery such as radial keratotomy or Lasik Surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Services or supplies provided by one of the following members of Your family: Spouse, Child, parent, in-law, brother, sister, or grandparent.
- Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood; b) Prescription Drugs not eligible under the "Prescription Drug Benefits" section of the Certificate of Coverage; and c) ovulation predictor kits. See also the separate exclusion addressing sterilization reversal.
- Except as stated in the Newborn hearing screening and hearing aids provisions, services or supplies related to hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.
- Services or supplies related to herbal medicine.
- Services or supplies related to hypnotism.
- Services or supplies related to medicinal marijuana.
- Elective abortions when prohibited by law.
- Abortions other than those described in the *Pregnancy, Pediatrics and Reproductive Benefits* section of this Certificate of Coverage.

- Services or supplies necessary because the Covered Person engaged, or tried to engage, in an illegal occupation or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.
- Services or supplies necessary while the Covered Person is in the custody of law enforcement.
- Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job, and which is covered or could have been covered for Benefits provided under Workers' Compensation, Employer's liability, occupational disease, or similar law. This does not apply to the following persons for whom coverage under Workers' Compensation is optional unless such persons are covered for Workers' Compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
- Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.
- Membership costs for health clubs, weight loss clinics, and similar programs.
- Services and supplies related to marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling, and related services, except as otherwise stated in this Certificate of Coverage.
- Charges for missed appointments.
- Charges for nicotine dependence treatments and management Drugs unless otherwise stated in the **PREVENTIVE AND WELLNESS CARE** chapter of this Certificate of Coverage.
- Any charge identified as a non-covered Charge or which is specifically limited or excluded elsewhere in this Certificate of Coverage, or which is not Medically Necessary and appropriate, except as otherwise stated in this Certificate of Coverage.
- Non-Prescription Drugs or supplies, except:
    - insulin needles and syringes and glucose test strips and lancets;
    - colostomy bags, belts, and irrigators; and
    - as stated in this Certificate of Coverage for food and food products for inherited metabolic diseases.
- Services provided by a pastoral counselor in the course of his or her normal duties as a religious person.
- Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.
- Services and charges related to gender transition.
- The following Exclusions apply specifically to Outpatient coverage of Prescription Drugs
    - Charges to administer an orally administered Drug.
    - Charges for Immunization agents related to travel or not approved by the ACIP,
    - Charges for a Prescription Drug which is labeled "Caution — limited by Federal Law to Investigational use"; or Experimental.
    - Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
    - Charges for refills dispensed after one (1) year from the original date of the Prescription.
    - Charges for controlled substances as a replacement for a previously dispensed controlled substance that was lost, misused, stolen, broken, or destroyed.
    - Charges for Drugs, except insulin, which can be obtained legally without a practitioner's Prescription.
    - Charges for a Self-Administered Injectable Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
        - an Inpatient Hospital
        - a rest home
        - a sanitarium
        - an extended care facility
        - a Hospice
        - a substance abuse center
        - an alcohol abuse or mental health center
        - a convalescent home
        - a nursing home or similar institution
        - a Provider's office

- Charges for:
  - Therapeutic devices or appliances without a Preauthorization;
  - Hypodermic needles or syringes, except insulin syringes; and
  - Other non-medical substances, regardless of their intended use.
- Charges for over-the-counter vitamins and dietary supplements
- Charges for any Drug used to treat baldness.
- Charges for Drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder.
- Covered Person taking part in the commission of a felony.
- Charges for Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- Charges for Drugs dispensed to a Covered Person while on active duty in any armed force.
- Charges for Drugs for which there is no charge. This usually means Drugs furnished by the Covered Person's Employer, labor union, or similar Group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.
- Charges for Drugs covered under the Home Health Care or Hospice Care subsections of the Certificate of Coverage.
- Charges for Drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which Benefits are payable by Workers' Compensation, or similar laws. Exception: This exclusion does not apply to the following persons for whom coverage under Workers' Compensation is optional unless such persons are covered for Workers' Compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
- Compounded Drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a valid Prescription Order unless as specified in the Formulary.
- Compounded Drugs that are available as a similar commercially available Prescription Drug product.
- Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined not to be a Covered Service.
- Drugs used solely for the purpose for weight loss.
- Life enhancement Drugs for the treatment of sexual dysfunction, (e.g., Viagra).
- Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.

- Services or supplies that are not furnished by an eligible Provider.
- Services related to Outpatient Private Duty Nursing care, except as provided under the Home Health Care subsection of this Certificate of Coverage.
- Services or supplies related to rest or convalescent cures.
- Room and board charges for a Covered Person in any facility for any period of time during which he or she was not physically present overnight in the facility.
- Except as stated in the **PREVENTIVE AND WELLNESS CARE** chapter, routine examinations, or Preventive Care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where definite symptomatic condition is present; or examinations or tests not required to diagnose or treat Illness or Injury.
- Services or supplies related to routine foot care except in conjunction with metabolic or periphereal vascular disease.
- Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care, and self-help training.
- Services provided by a social worker, except as otherwise stated in this Certificate of Coverage.
- Services or supplies:
  - Eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;

    - For which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair;
    - For which a Covered Person would not have been charged if he or she did not have health care coverage;
    - For which the Covered Person has no legal obligation to reimburse the Provider;
    - Provided by or in a government Hospital except as stated below, or unless the services are for treatment:
        - Of a non-service Emergency; or
        - By a Veterans' Administration Hospital of a non-service-related Illness or Injury; Exception: This Exclusion does not apply to military retirees, their Dependents, and the Dependents of active-duty military personnel who are covered under both this Certificate of Coverage and under military health coverage and who receive care in facilities of the Uniformed Services.
        - Provided outside the United States other than in the case of Emergency and except as provided below with respect to a full-time student. Exception: Subject to Our pre-approval, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been pre-approved by Us are non-Covered Charges.
- Travel to obtain medical treatment, Drugs or supplies is not covered. In addition, We will not cover treatment, Drugs, or supplies that are unavailable or illegal in the United States.
- Stand-by services required by a Provider.
- Sterilization reversal and services and supplies rendered for reversal of sterilization.
- Charges for third party requests for physical examinations, Diagnostic Services, and Immunizations in connection with: obtaining or continuing employment; obtaining or maintaining a license issued by a municipality, state, or federal government; obtaining Benefits coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.
- Transplants, except as otherwise listed in this Certificate of Coverage.
- Transportation, travel.
- Vision therapy.
- Services or supplies received as a result of a war, or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area.
- Weight reduction or control including medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise, or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.
- Wigs, toupees, hair transplants, hair weaving or any Drug if such Drug is used in connection with baldness with the exception of hair loss following chemotherapy/radiotherapy up to one (1) per lifetime up to $500.
- Complications from services, supplies, and treatment for services that are not covered under this Plan.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

Prescription Drug reimbursement is subject to and treated as part of any Benefit maximums, or any other Exclusions or Limitations contained in this Plan. In addition, reimbursement will not be provided for:

- Any covered Drugs or charges for which Benefits are available under the Medical Benefits unless otherwise specified on the Formulary. For example, any medications taken during an Inpatient Hospital stay.
- Any Drugs that are not on the Prescription Drug Formulary and not otherwise approved for coverage through the non-Prescription Drug Formulary exception process.
- Drugs and medications not requiring a Prescription, except insulin and certain over the counter (OTC) products listed on the Formulary.
- Non-medical substances or items, with the exception that pharmaceuticals to aid smoking cessation are covered.
- Dietary supplements, cosmetics, health, or beauty aids unless otherwise specified on the Formulary.
- Any over-the-counter vitamin, mineral, herb, or botanical product which is thought to have health Benefits, but does not have a Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition, even if it is thought to have health Benefits unless otherwise specified on the Formulary.
- Drugs taken while the Member is in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital, or similar facility.
- Drugs not approved by the Food and Drug Administration (FDA) or recognized by standard Drug reference compendium, or substantially accepted peer-reviewed medical literature for use in humans or for the condition, dose, route, duration, and frequency being treated.
- Syringes and/or needles, except those dispensed for use with insulin or Self-Administered Injectable Drugs.
- Durable Medical Equipment, devices, appliances, and supplies except as specifically stated under the Professional and Other Services subsection of this Certificate of Coverage.
- Immunizing agents, biological sera, blood, blood products or blood plasma.
- Oxygen.
- Drugs and medications dispensed or administered in an Outpatient setting, including but not limited to Outpatient Hospital facilities and doctor's offices. Such Drugs and medications are covered under the Professional and Other Services Benefit.
- Drugs used for cosmetic purposes.
- Drugs used for the primary purpose of treating Infertility or promoting fertility, except in association with an approved Course of Treatment for In-Vitro Fertilization and specified on the Formulary.
- Anorexiants or Drugs associated with weight loss or for the treatment of obesity, except as provided under Child and Adult Preventive Care Services.
- Drugs obtained while traveling outside the United States.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy is excluded under this Plan, except as specifically stated otherwise in this Certificate of Coverage.
- Drugs for treatment of a condition, Illness, or Injury for which Benefits are excluded or limited by a Certificate of Coverage limitation.
- Select classes of Drugs where non-preferred medications, which have therapeutic, alternatives, have shown no Benefit regarding efficacy or side effects over Preferred Drugs. However, this will not apply if the prescriber denotes “Dispense as Written” or “Do Not Substitute” but may still need to meet Prior Authorization or other Utilization Management criteria and may have higher Cost Share.
- Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent, except insulin and certain OTC products listed on the Formulary.
- High-cost drugs that are chemically similar Drugs and share the same mechanism of action to an existing, approved chemical entity and offer no significant clinical benefit.
- Replacement of lost or stolen Prescription Drugs except as approved by the Plan, other Limitations may exist.

- Experimental or Investigational Drugs or products that have not been proved as safe and effective or are not supported by peer-reviewed literature or compendia.
- Anything which is not specified as covered or not defined as a Drug, such as therapeutic devices, appliances, support garments, glucometers, asthma spacers and machines, including syringes (except disposable syringes for insulin dependent Members) unless listed on Our Formulary.

GENERAL PROVISIONS

Consumer Rights and Responsibility

You have rights and responsibilities as a Member of MHHIC. As a parent, caretaker, or legal guardian of a juvenile consumer or Member, You have rights and responsibilities, as well as liability.

You have the right to:

- Receive coverage for covered medical Benefits and treatment that are available when You need them and that are handled in a way that is fair, and respects Your privacy and dignity.
- Receive information You need about Your health Benefit Plan, including information about services that are covered and not covered and any costs that You will be responsible for paying, in a language You understand, including that language in written form when requested.
- Receive Covered Services. Your race, ethnic group, original country, language, religion, gender, and age do not matter. Your mental or physical disabilities, sexual orientation and Family medical history do not matter.
- Obtain information about the qualifications of clinical staff that support MHHIC programs and services.
- Have access to a current list of in-network doctors, Hospitals, and places You can receive care and information about a particular doctor's education, training, and practice.
- Select a Primary Care Provider for Yourself and each Member of Your Family per Your Benefit Plan, and change Your Primary Care Provider for any reason.
- Have Your medical information kept confidential by MHHIC and Your doctor. MHHIC complies with the confidentiality of all consumers' information and adheres to all federal and state regulations regarding confidentiality and the release of personal health information.
- Inspect, review, and receive copies of Your health and billing records that are held by health Plans and health care Providers covered under HIPAA.
- Participate with Your healthcare professional in treatment decisions and have Your healthcare professional give You information about Your medical condition and Your treatment options/risk, regardless of coverage or cost. Members who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, Family members or other conservators. You have the right to receive this information in terms and language You understand.
- Be asked for Your consent for all care, unless there is an Emergency and Your life and health are in serious danger, and have the opportunity to learn about any care You receive.
- Be advised of who is available to assist You with any special MHHIC programs or services You receive and who can assist You with any requests to change programs or services.
- Access Emergency healthcare services when and where the need arises.
- Refuse medical care. If You refuse medical care, ask what happens if You refuse treatment. We urge You to discuss Your concerns about care with Your Primary Care Provider or other Network healthcare professional. Your doctor or healthcare professional will give You advice, but You will have the final decision.
- A fair, efficient, and reasonable process for resolving differences of Your Complaint(s) or concern about MHHIC and/or the quality of care You receive from healthcare professionals and the various places You receive care in Our Network; provide a courteous, prompt response; including guidance through Our process for Appeal of an Adverse Determination if You do not agree with Our decision.
- Make recommendations regarding MHHIC policies that affect Your rights and responsibilities.

You have the responsibility to:

- Review and understand the information You receive about Your health benefit Plan and any rules for getting care. Please call Customer Service at 855-645-8448 when You have questions or concerns.
- Understand how to obtain services and supplies that are covered under Your Plan.
- Show Your ID card before You receive care and not allow anyone else to use Your ID card with the purpose of fraud and abuse.
- Respect the healthcare professionals who are giving You care and follow their advice.
- Schedule an appointment with any Network Provider for care needed, build a comfortable relationship with Your Provider, ask questions about things You don't understand and follow Your Provider's advice. Know that Your condition may not improve and may even get worse if You don't follow Your healthcare professional's advice.

- Understand Your health condition and work with Your Provider to develop a treatment plan with goals upon which You both agree. Ask for more information if You do not understand Your health condition or treatment.
- Provide honest, complete information to the healthcare professionals caring for You. Know that dishonesty compromises Your healthcare.
- Know what medicine You take, and why and how to take it.
- Pay all Copayments, Deductibles, the Prescription Drug Deductible, if any, for which You are responsible at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the healthcare professional's office within 24 hours if You are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by Your Plan.
- Voice Your opinions, concerns, or Complaints to MHHIC Customer Service and/or Your healthcare professional.
- Notify MHHIC and Your treating healthcare professional as soon as possible about any changes in Family status, address, phone number or status with other health Benefit coverage.

Access to Information

We can also give You information in alternate formats if You need it. If You are eligible for Medicare because of a disability, We are required to give You information about the Plan's Benefits that is accessible and appropriate for You.

If You have any trouble getting information from Our Plan because of problems related to language or a disability, please call Customer Service at the telephone number shown on the "Contact Information" page at the beginning of this Certificate of Coverage, and tell them that You want to file a Complaint.

Alternate Cost Containment

If it will result in less expensive treatment, We may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies that are otherwise limited or excluded by the Plan. It must be mutually agreed to by Us, You, and Your Physician, Provider, or other health care practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent MHHIC from strictly applying the express Benefits, Limitations, and Exclusions of the Plan at any other time or for any other Member.

Amendments

We may make amendments to the Certificate of Coverage upon renewal with a 60-days' notice to the Certificate of Coverage holder as noted below. An amendment will not affect Benefits for service or supplies furnished before the date of change; and no change to the Benefits under this Certificate of Coverage will be made without approval from an officer of the health Plan.

Only Our officers have authority to waive any conditions or restrictions of the Certificate of Coverage, to extend the time in which a Premium may be paid, to make or change a Certificate of Coverage, or to bind Us by a promise or representation or by information given or received. No change in the Certification of Coverage is valid unless the change is shown in one of the following ways:

- it is uniformly applied to all Subscribers;
- it is shown in an endorsement signed by one of Our officers;
- if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Certificate of Coverage, as provided in the section of this Certificate of Coverage called **Conformity with Law**, it is shown in an amendment to it that is signed by one of Our officers;
- if a change is required by Us, it is accepted by the Certificate of Coverage holder, as evidenced by payment of a Premium on or after the effective date of such change; or
- if a written request for a change is made by the Certificate of Coverage holder, it is shown in an amendment to it signed by the Certificate of Coverage holder and by one of Our officers.

Assignment

No assignment or transfer by the Certificate of Coverage holder of any of the Certificate of Coverage holder's interest under this Certificate of Coverage or by a Covered Person of any of his or her interest under this Certificate of Coverage is valid unless We consent.

Clerical Error – Misstatements

No clerical error or programming or systems error by the Certificate of Coverage holder or by Us in keeping any records pertaining to coverage under this Certificate of Coverage will reduce a Covered Person's coverage, nor will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments involving return of unearned Premium to the Certificate of Coverage holder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If any relevant facts are found to have been misstated, and the Premiums are thereby affected, an equitable adjustment of Premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, subject to this Certificate of Coverage's **Incontestability sub**section, the true facts will be used in determining whether coverage is in force under the terms of this Certificate of Coverage.

Time Limit on Certain Defenses

This provision limits Our use of statements by the Group and/or Member in contesting coverage under this Plan. All statements made by the Group and/or Member shall be considered representations and not warranties. We issue this coverage based upon statements made by the Group and/or Member.

The statements are considered to be truthful and are made to the best of the Group's and/or Member's knowledge and belief.

The following rules apply to each statement, except statements relating to health status. The statement will not be used in a contest to void, cancel or non-renew the coverage unless:

- It is in a written Enrollment Form signed by the Group or Member;
- A copy of the Enrollment Form is or has been furnished to the Group or to the Member or to the Member's personal representative; and
- Within the first two (2) Years of the issue date, it is an intentional misrepresentation that is material to Our agreement to issue this Policy, or after two (2) Years, the Application contains a fraudulent misstatement.

Misstatements of tobacco usage on the Enrollment Form shall not be used to void, cancel or non-renew this coverage. We may increase the Premium for this Plan to the appropriate level if We determine that the Group or a Member made a misstatement of tobacco usage on the Enrollment Form.

Complaints

If You have a Complaint about anything related to Our coverage, You may contact Us at the telephone number or address shown on the "Important Notice" page at the beginning of this Certificate of Coverage. You may also contact the Texas Department of Insurance (TDI); contact information for TDI is also provided on the "Important Notice" page.

If Your Complaint concerns an Adverse Determination (denial of coverage) on proposed or received services or treatment, please see the section entitled **Appeal of Adverse Determinations** in the **COMPLAINTS & APPEALS** chapter of Your Certificate of Coverage.

Please be advised that We may not engage in any retaliatory action against You, including cancelling or refusing to renew Your coverage because You or a person acting on Your behalf has filed a Complaint against Us or Appealed Our Adverse Determination. Further, We may not engage in any retaliatory action, including refusing to renew or terminating a Contract, against a Physician or other health care Provider because the Physician or Provider, on Your behalf, reasonably filed a Complaint against Us or Appealed Our Adverse Determination.

Conformity with Law

Any provision of this Certificate of Coverage which is in conflict with the laws of the State of Texas, or with federal law, will be construed and applied as if it were in full compliance with the minimum requirements of such state law or federal law.

Continuing Rights

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Certificate of Coverage.

Coordination Of This Plan's Benefits With Other Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. The Order of Benefit Determination rules govern the order in which each Plan will pay a Claim for Benefits. The Plan that pays first is called the primary Plan. The primary Plan must pay Benefits in accordance with its Certificate of Coverage terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the Benefits it pays so that payments from all Plans equal 100% of the total Allowable Expense.

For clarification:

1. A "Plan" is any of the following that provides Benefits or services for medical, dental, or vision care or treatment. If separate Contracts are used to provide coordinated coverage for Members of a Group, the separate Contracts are considered parts of the same Plan and there is no COB among those separate Contracts.

    a) "Plan" includes: Group, blanket, or franchise accident and health Benefits policies, excluding disability income protection coverage; individual and Group health insurance company Certificates of Coverage; individual accident and health Benefits policies; individual and Group Network Provider Benefit Plans and exclusive Provider Benefit Plans; Group Benefits Contracts, individual Benefits Contracts and Subscriber Contracts that pay or reimburse for the cost of Dental Care; a vision Benefit plan that provides coverage for vision or eye care expenses;; medical care components of individual and Group long-term care Contracts; limited Benefit coverage that is not issued to supplement individual or Group in force policies; uninsured (i.e., self-funded or self-insured) arrangements of Group or Group-type coverage; the medical Benefits coverage in automobile insurance Contracts; and Medicare or other governmental Benefits, as permitted by law.

    b) "Plan" does not include: disability income protection coverage; the Texas Health Insurance Pool; Workers' Compensation insurance coverage; Hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental Benefit coverage; accident only coverage; specified accident coverage; school accident-type coverage that covers students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; Benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and Custodial Care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state Plan under Medicaid; a governmental Plan that, by law, provides Benefits that are in excess of those of any private insurance Plan; or other nongovernmental Plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable Deductible.

Each Contract for coverage under (1) (a) or (1) (b) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. "This Plan" means, in a COB provision, the part of the Certificate of Coverage providing the health care Benefits to which the COB provision applies, and which may be reduced because of the Benefits of other Plans. Any other part of the Certificate of Coverage providing health care Benefits is separate from this Plan. A Contract may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with like Benefits, and may apply other separate COB provisions to coordinate other Benefits.

    The Order of Benefit Determination rules determine whether "this Plan" is a primary Plan or secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines

payment for its Benefits first before those of any other Plan without considering any other Plan's Benefits. When this Plan is secondary, it determines its Benefits after those of another Plan and may reduce the Benefits it pays so that all Plan Benefits equal 100% of the total Allowable Expense.

3. "Allowable Expense" is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides Benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a health care Provider or Physician by law or in accord with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:

   a) the difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.

   b) if a person is covered by two or more Plans that do not have negotiated fees and compute their Benefit payments based on the Usual and Customary fees, Allowed Amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific Benefit is not an Allowable Expense.

   c) if a person is covered by two or more Plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d) if a person is covered by one Plan that does not have negotiated fees and that calculates its Benefits or services based on Usual and Customary fees, Allowed Amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another Plan that provides its Benefits or services based on negotiated fees, the primary Plan's payment arrangement must be the Allowable Expense for all Plans. However, if the health care Provider or Physician has contracted with the secondary Plan to provide the Benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the health care Provider's or Physician's Contract permits, the negotiated fee or payment must be the Allowable Expense used by the secondary Plan to determine its Benefits.

   e) the amount of any Benefit reduction by the primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, Preauthorization of Admissions, and Network health care Provider and Physician arrangements.

4. "Allowed Amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a Out-of-Network health care Provider or Physician. The Allowed Amount includes both the carrier's payment and any applicable Deductible, Copayment, or Coinsurance amounts for which the Member is responsible.

5. "Closed Panel Plan" is a Plan that provides health care Benefits to Covered Persons primarily in the form of services through a panel of health care Providers and Physicians that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other health care Providers and Physicians, except in cases of Emergency or Referral by a panel member.

6. "Custodial Parent" is the parent with the right to designate the primary residence of a Child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the Child resides more than one-half of the Calendar Year, excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of Benefit payments are as follows:

a. The primary Plan pays or provides its Benefits according to its terms of coverage and without regard to the Benefits under any other Plan.
b. Except as provided in (#3 above), a Plan that does not contain a COB provision that is consistent with this Plan is always primary unless the provisions of both Plans state that the complying Plan is primary.
c. Coverage that is obtained by virtue of membership in a Group that is designed to supplement a part of a basic package of Benefits and provides that this supplementary coverage must be excess to any other parts of the Plan provided by the Certificate of Coverage holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan Hospital and surgical Benefits, and insurance type coverages that are written in connection with a closed panel Plan to provide out-of-network Benefits.
d. A Plan may consider the Benefits paid or provided by another Plan in calculating payment of its Benefits only when it is secondary to that other Plan.
e. If the primary Plan is a closed panel Plan and the secondary Plan is not, the secondary Plan must pay or provide Benefits as if it were the primary Plan when a Covered Person uses a Out-of-Network health care Provider or Physician, except for Emergency services or Authorized referrals that are paid or provided by the primary Plan.
f. When multiple Contracts providing coordinated coverage are treated as a single Plan for the purposes of COB under this subchapter, this section applies only to the Plan as a whole, and coordination among the component Contracts is governed by the terms of the Contracts. If more than one carrier pays or provides Benefits under the Plan, the carrier designated as primary within the Plan must be responsible for the Plan's compliance with this subchapter.
g. If a person is covered by more than one secondary Plan, the Order of Benefit Determination rules of this subchapter decide the order in which secondary Plans' Benefits are determined in relation to each other. Each secondary Plan must take into consideration the Benefits of the primary Plan or Plans and the Benefits of any other Plan that, under the rules of this Certificate of Coverage, has its Benefits determined before those of that secondary Plan.
h. Each Plan determines its order of Benefits using the first of the following rules that apply:
    1. Nondependent or Dependent: The Plan that covers the person other than as a Dependent, for example as an Employee, Member, Certificate of Coverage holder, Subscriber, or retiree, is the primary Plan, and the Plan that covers the person as a Dependent is the secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent and primary to the Plan covering the person as other than a Dependent, then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an Employee, Member, Certificate of Coverage Contract holder, Subscriber, or retiree is the secondary Plan, and the other Plan is the primary Plan. An example includes a retired Employee.
    2. Dependent Child Covered Under More Than One Plan: Unless there is a court order stating otherwise, Plans covering a Dependent Child must determine the order of Benefits using the following rules that apply.
        a. Dependent Child(ren) whose parents are married or are living together, whether or not they have ever been married:
            i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the primary Plan; or
            ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.
        b. Dependent Child(ren) whose parents are divorced, separated, or not living together, whether or not they have ever been married:
            i. If a court order states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan Years commencing after the Plan is given notice of the court decree.
            ii. If a court order states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of (h)(2)(a) must determine the order of Benefits.
            iii. If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of (h)(2)(a) must determine the order of Benefits.

    iv. If there is no court order allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of Benefits for the Child are as follows:
        a. the Plan covering the custodial parent;
        b. the Plan covering the Spouse of the custodial parent;
        c. the Plan covering the noncustodial parent; then
        d. the Plan covering the Spouse of the noncustodial parent.
  c. For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of (h)(2)(a) or (h)(2)(b) must determine the order of Benefits as if those individuals were the parents of the Child.
  d. For a Dependent Child who has coverage under either or both parents' Plans and has his or her own coverage as a Dependent under a Spouse's Plan, (h)(5) applies.
  e. In the event the Dependent Child's coverage under the Spouse's Plan began on the same date as the Dependent Child's coverage under either or both parents' Plans, the order of Benefits must be determined by applying the birthday rule in (h)(2)(a) to the Dependent Child's parent(s) and the Dependent's Spouse.

3. Active, Retired, or Laid-off Employee: The Plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary Plan. The Plan that covers that same person as a retired or laid-off Employee is the secondary Plan. The same would hold true if a person is a Dependent of an Active Employee and that same person is a Dependent of a retired or laid-off Employee. If the Plan that covers the same person as a retired or laid-off Employee or as a Dependent of a retired or laid-off Employee does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of Benefits.
4. COBRA or State Continuation Coverage: If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, Member, Subscriber, or retiree or covering the person as a Dependent of an Employee, Member, Subscriber, or retiree is the primary Plan, and the COBRA, state, or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of Benefits.
5. Longer or Shorter Length of Coverage: The Plan that has covered the person as an Employee, Member, Certificate of Coverage Contract holder, Subscriber, or retiree longer is the primary Plan, and the Plan that has covered the person the shorter period is the secondary Plan.
6. If the preceding rules do not determine the order of Benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

Effect on the Benefits of this Plan

When this Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the secondary Plan will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total Benefits paid or provided by all Plans for the Claim equal 100% of the total Allowable Expense for that Claim. In addition, the secondary Plan must credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Covered Person is enrolled in two or more closed panel Plans and if, for any reason, including the provision of service by a non-panel Provider, Benefits are not payable by one closed panel Plan; COB must not apply between that Plan and other closed panel Plans.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan and other Plans. MHHIC will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining Benefits payable under this Plan

and other Plans covering the person claiming Benefits. Each person claiming Benefits under this Plan must give MHHIC any facts it needs to apply those rules and determine Benefits.

Right of Recovery

If the amount of the payments made by MHHIC is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the Benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

MHHIC has 180 days from the date the payment was received by the payee to request the return of an overpayment.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, MHHIC may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under this Plan. MHHIC will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means the reasonable cash value of the Benefits provided in the form of services.

Governing Law

This entire Certificate of Coverage is governed by the laws of the State of Texas.

Incontestability of the Certificate of Coverage

There will be no contest of the validity of the Certificate of Coverage, except for not paying Premiums, after it has been in force for two (2) Years. No statement in any Application or Enrollment Form, except a fraudulent statement, made by the Certificate of Coverage holder or by a Covered Person covered under this Certificate of Coverage will be used in contesting the validity of his or her coverage or in denying Benefits after such coverage has been in force for two (2) Years during the person's lifetime. There is no time limit with respect to a contest in connection with fraudulent statements. Fraudulent statements do not include misrepresentation related to health status.

Limitation on Actions

No action at law or in equity will be brought to recover on the Certificate of Coverage until 60 days after a Covered Person files written proof of loss. No such action will be brought more than three (3) Years after the end of the time with which proof of loss is required.

Medicare Eligible Individuals

This Plan is not a supplement to Medicare. The Plan provides Benefits according to a Non-Duplication of Medicare clause. When a Member becomes eligible for Medicare Benefits, We automatically become the secondary health Plan to Part B of Medicare for Members meeting any of the following criteria:

- Members who are eligible for Medicare due to a disability and are under age 65;
- Members following the first 30 months of kidney dialysis treatments for end-stage renal disease;
- Members who have received a kidney transplant within the first 3 months after starting a course of kidney dialysis treatments for end-stage renal disease;
- Members who have enrolled in a self-dialysis training program, and received training for home dialysis for treatment of end-stage renal disease; or
- Members enrolled 30 days or more after being diagnosed with Amyotrophic Lateral Sclerosis (ALS).

We remain the primary health Plan for Medicare beneficiaries not meeting any of the above listed criteria.

Non-Duplication of Medicare Benefits

If Medicare is a Member's primary health coverage, We will provide Claim payment according to this Plan minus any amount paid by Medicare.

Conformity with Medicare Supplement and Long-Term Care Minimum Standards

The Texas Department of Insurance has rules that govern minimum standards for Group health Plans, Medicare supplement policies, and long-term care policies. If there is a conflict between the Medicare supplement or long-term care rules, or both, and the Plan rules, the Medicare supplement or long-term care rules will govern to the Exclusion of the conflicting provisions of the Plan rules. Where there is no conflict, the Plan must follow the Medicare supplement, the long-term care rules, and the Plan rules where applicable.

Benefits for Medicaid Eligible Member*s*

Members eligible for Medicaid receive full Benefits of this Plan. Benefits will not be reduced due to their eligibility for Medicaid. However, in order to receive Benefits, the services must be for medical services covered under this Plan, and are subject to all other restrictions of this Plan.

Benefits Provided by the Texas Health and Human Services Commission

When services rendered are paid for by the Texas Health and Human Services Commission on behalf of a Member, payment for the services will be made directly to the Texas Health and Human Services Commission. In the case of a Dependent Child, when services rendered are paid for by the Texas Health and Human Services Commission on behalf of such Dependent Child, payment for the services will be made directly to the Texas Health and Human Services Commission if:

- the parent who is the Subscriber is:
  - a possessory conservator of the Child under an order issued by a court in this state; or
  - is not entitled to possession of or access to the Child, and is required by court order or court-approved agreement to pay Child support;
- the Texas Health and Human Services Commission is paying Benefits on behalf of the Child under Chapter 31 or Chapter 32, Human Resources Code; and
- We are notified through an attachment to the Claim for covered Benefits when the Claim is first submitted to Us that the Benefits must be paid directly to the Texas Health and Human Services Commission.

Except as provided here, no Benefits are payable for expenses incurred after the date of any termination of coverage. For information about the right to continue coverage, refer to the **Continuation of Coverage** provision.

Notices and Other Information

Any notices, documents, or other information under the Certificate of Coverage may be sent by United States mail, postage prepaid, addressed as follows:

- If to Us: to Our last address on record with the Certificate of Coverage holder.
- If to the Certificate of Coverage holder: to the last address provided by the Certificate of Coverage holder on an enrollment or change of address form delivered to Us.
- If to a Covered Person: to the last address provided by the Covered Person on an enrollment or change of address form delivered to Us.

Payment of Premiums - Grace Period

Premiums are to be paid by Your Employer to Us. They are due on each Premium due date. You may pay each Premium other than the initial Premium within thirty-one (31) days after the monthly Premium due date. Those days are known as the Grace Period. You are liable to pay Premiums to Us from the first day the Certificate of Coverage is in force in order for this Certificate of Coverage to be considered in force on a Premium-paying basis. You will be liable for the monthly payment of the Premium for the time the Certificate of Coverage stays in effect. If any Premium is not paid by thirty (30) days from the end of the Grace Period, coverage will terminate at the end of the period for which Premium has been paid. The Covered Person is responsible for the payment of Premium and charges incurred for services or supplies received during the Grace Period.

Premium Rate Changes

We have the right to prospectively change Premium rates as of any of these dates:

- any Premium due date;
- any date that the extent or nature of the risk under the Certificate of Coverage is changed:
  - by amendment of the Certificate of Coverage;

- by reason of any provision of law or any government program or regulation; or
- at the discovery of a clerical error or misstatement as described in the **GENERAL PROVISIONS** chapter of this Certificate of Coverage.

We will give You 60 days' advance written notice when a change in the Premium rates is made. We may change the Premium rates from time to time but no more frequently than quarterly.

Statements

No statement will void the coverage, or be used in defense of a Claim under this Certificate of Coverage, unless it is contained in a writing signed by a Covered Person, and We furnish a copy to the Covered Person. All statements will be deemed representations and not warranties.

Large Group Employer's Renewal Privilege and Plan Termination

All periods of covered Benefits hereunder will begin and end at 12:01 am. Central Standard Time.

The Large Group Employer (the Group) may renew this Certificate of Coverage each Plan Year. All renewals are subject to the payment of Premiums then due, computed as provided in this Certificate of Coverage's Premium Rates subsection and to the provisions stated below.

We have the right to non-renew this Certificate of Coverage on the renewal date following written notice to the Commissioner of Insurance and Certificate of Coverage holder for the following reasons:

- Subject to 180 days' advance written notice, We cease to do business in the Large Employer Group health Benefits market;
- Subject to 90 days' advance written notice, We cease offering and non-renew a particular type of health Benefits Plan in the Large Employer Group market provided We act uniformly without regard to any health status-related factor of Covered Persons or persons who may become eligible for coverage, and We offer the Subscriber on a guaranteed issue basis the option to purchase any other Large Employer group health Benefit Plan available at the time of the discontinuance.

During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its Grace Period, the Certificate of Coverage will end as described in the Grace Period provision.

Termination by Request: If the Large Group Employer wants to replace this Certificate of Coverage with another health Benefits Plan (subject to MHHIC restrictions), the Group must give Us notice of the replacement within 30 days after the Effective Date of the new Plan. This Certificate of Coverage will end as of 12:01 a.m. on the Effective Date of the new Plan and any unearned Premium will be refunded. If the Group wants to end this Certificate of Coverage and does not want to replace it with another Plan, the Group may write to Us, in advance, to ask that the Certificate of Coverage be terminated at the end of any period for which Premiums have been paid. Then the Certificate of Coverage will end on the date requested.

This Certificate of Coverage will be renewed automatically each year on the renewal date, unless coverage is terminated on or before the renewal date due to one of the following circumstances:

- The Group has failed to pay Premiums in accordance with the terms of the Certificate of Coverage, or We have not received timely Premium payments (Coverage will end as described in the **Grace Period** provision.)
- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Certificate of Coverage; (Coverage will end as of the Effective Date, subject to the **Incontestability** provision).
- With respect to a Covered Person other than a Dependent, termination of eligibility if the Member is no longer a resident, (We will give the Member at least 30 days' written notice that coverage will end.)
- The Group becomes covered under another health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the other health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the Effective Date of the new Plan.).
- Another reason prescribed by rules adopted by the Commissioner.

Third Party Liability and Rights of Subrogation

No Benefits are payable for any Illness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, We will advance the Benefits of this Plan to You subject to the following:

- By receiving Benefits from MHHIC under this Certificate of Coverage, You and Your covered Dependents assign to MHHIC the right to proceed in Your or Your Covered Dependents' name to secure rights of recovery of MHHIC's costs, expenses, or the value of services rendered. The value of services rendered which MHHIC is entitled to recover will be limited to the cost of providing such services. MHHIC is entitled to discharge its subrogation rights on a prorata basis with any other contractual or statutory subrogation holder.
- An issuer of a plan that provides Benefits under which the Policy or plan may be obligated to make payments or provide medical or surgical Benefits to or on behalf of a covered individual as a result of a personal Injury to the individual caused by a third-party may contract to be subrogated to and have a right to reimbursement for payments made or costs of Benefits provided from the individual's recovery for that Injury, in accordance with the Texas Civil Practices and Remedies code, Title 6, Chapter 140.
- If another person or entity is, or may be, responsible to pay for or provide health care services to You or Your covered Dependent and if MHHIC paid for or provided those health care services, then MHHIC is entitled to subrogation rights against such person or entity. MHHIC is also entitled to recover from You or Your covered Dependent the value of services provided, arranged, or paid for, when You or Your covered Dependent are reimbursed for the cost of care by another party, including You or Your covered Dependent's auto insurance for uninsured motorist and underinsured motorist coverage provided that You or Your immediate Family did not pay the Premiums for the coverage. MHHIC is also entitled to recover its costs and expenses related to recovery activities.
- You agree to advise MHHIC, in writing, within 60 days of any Member's Claim against the third party and to take such reasonable action, provide such information and assistance, and execute such paper as We may require facilitating enforcement of the Claim. You also agree to take no action that may prejudice Our rights or interests under this Certificate of Coverage. Failure to provide notice of a Claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this Certificate of Coverage and will result in You being personally responsible for reimbursing Us.
- If an injured covered individual is entitled by law to seek a recovery from the third-party tortfeasor for Benefits paid or provided by a subrogee, then all payors are entitled to recover as provided by subsection (b) or (c) of the Texas Civil Practices and Remedies code, Title 6, Chapter 140. This applies when a covered individual is or is not represented by an Attorney.
- We will automatically have a lien, to the extent of Benefits advanced, subject to the maximum recoverable amount allowed under the Texas Civil Practices and Remedies Code, Chapter 140, upon any recovery that any Member receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of Benefits paid by Us under this Plan for the treatment of the Illness, disease, Injury or condition for which the third party is liable, subject to the maximum recoverable amount allowed under the Texas Civil Practices and Remedies Code, Chapter 140.
- You and Your Covered Dependents will cooperate fully in the exercise of these rights of subrogation, to the extent they comply with applicable law, and will take no action or refuse to take any action that would prejudice the rights of MHHIC. You or Your covered Dependents may not settle, compromise, or release a Claim against a third party unless (1) the rights of MHHIC are expressly reserved in the settlement, compromise or release and You advise the MHHIC in writing within such period of time as is reasonably necessary to protect MHHIC's rights, or (2) MHHIC is paid in full up to the Benefits paid by MHHIC for that Injury, or (3) MHHIC has given a written waiver of Claim after notice. MHHIC reserves the right to select its own representation; including legal representation, in pursuit of its subrogation rights herein.
- You or Your covered Dependents will distribute to MHHIC any subrogation recoveries, which are limited to the lesser of one-half of the gross recovery minus attorney fees, if applicable, and the total cost of Benefits paid, provided, or assumed under this Certificate of Coverage as a direct result of the wrongful conduct of the third party minus attorney fees, if applicable.

Workers' Compensation

The health Benefits provided under this Certificate of Coverage are not in place of, and do not affect requirements for coverage by Workers' Compensation.

Discrimination

MHHIC may not refuse to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's race, color, religion, or national origin, age, gender, marital status, or geographic location, disability, or partial disability.

MEMORIAL HERMANN Health Plan Commercial Group Plans

Schedule of Benefits

Notes:

- Copayments (Copay) - The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider. The Copayment amount does not count towards the Deductible.
- Single Highest Copay applies when multiple services that are subject to individual Copayments are performed on the same day by the same Network Provider. Please check your Certificate of Coverage for details.
- If an Out-of-Network provider charges more than the Allowed Amount, You may have to pay the difference.
- Some benefits may require Preauthorization. Please check your Certificate of Coverage for details.
- Please read the entire Certificate of Coverage for other Covered Services, Benefits, Exclusions, & Limitations.
- Benefits are applied per Calendar Year.
- This Certificate of Coverage does not cover Cosmetic Surgery, dental or routine eye care (adult), Infertility treatment, long term care, weight loss programs, or non- emergency care when traveling outside the United States.
- In-Network Benefits are paid based on the Negotiated Rate.
- The Emergency Room Service Copayment does not count toward satisfying the Deductible.

2026 Schedule of Benefits – Select 1500-80 PPO		
Annual	**Network Provider**	**Out-of-Network Provider**
Individual Deductible:	$1,500	$3,000
Family Deductible:	$3,000	$6,000
Individual Out-of-Pocket Maximum:	$5,000	$10,000
Family Out-of-Pocket Maximum:	$10,000	$20,000
Coinsurance:	20%	50%
Payment Order:	Copayment applies first (if applicable), then Deductible, then Coinsurance (if applicable).Copayment counts toward Maximum Out-of-Pocket amount.	

Schedule of Benefits				
Common Medical Event	**Services You May Need**	**Network Provider**	**Out-of-Network Provider**	**Exclusions & Limitations and Other Important Information**
If you visit a health care Provider's office or clinic	Primary care visit to treat an Illness or Injury	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	None

If you visit a health care Provider's office or clinic	Specialist visit	$50 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	None
	Preventive care/screening/ Immunizations	No charge Deductible does not apply	50% Coinsurance Deductible applies first	For Children under the age of 6: required Immunizations are not subject to Deductible, Copayment, or Coinsurance requirements for Network Providers. You may have to pay for services that aren't preventive. Ask your Provider if the services needed are preventive. Then check what Your Plan will pay for.
If you have a test	Diagnostic tests – Blood work	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	Professional/ interpretation service is included in diagnostic blood work and x-ray Cost Share. Preauthorization required for all genetic testing and complex imaging.
	Diagnostic tests - X-rays	$50 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	
	Imaging (CT/PET scans, MRIs)	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	
If you need immediate medical attention	Emergency room services	$400 Copay/visit Deductible does not apply		Copayment waived if admitted
	Emergency medical transportation	20% Coinsurance Deductible applies first		None
	Urgent Care	$50 Copay/visit Deductible does not apply	$100 Copay/visit Deductible does not apply	None
If you have a Hospital stay	Facility fee (e.g., Hospital room)	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Preauthorization required.
	Physician/surgeon fees	No charge	50% Coinsurance Deductible applies first	In-network: Cost included in Inpatient stay.

If you have Outpatient Surgery	Facility fee (e.g., ambulatory surgery center)	Hospital - 20% Coinsurance Deductible applies first Freestanding clinic - $300 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	Preauthorization required.
	Physician/surgeon fees	No charge	50% Coinsurance Deductible applies first	In-network: Cost included in Outpatient facility fee. Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Professional Office Visits	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	Preauthorization required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy
	Outpatient services	No charge Deductible does not apply	50% Coinsurance Deductible applies first	
	Inpatient services	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Preauthorization required.
If you are pregnant	Office visits	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	Preauthorization required for Inpatient stay that exceeds the 48/96-hour timeframe as outlined in the Certificate of Coverage (COC). Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	50% Coinsurance Deductible applies first	
	Childbirth/delivery facility services	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	
Oral Contraceptives & contraceptive services and devices	All FDA approved devices - educational services & counseling	No charge	50% Coinsurance Deductible applies first	Not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available.
If you need help recovering or have special health needs	Home Health Care	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Limited to 60 visits per Year. Preauthorization required

If you need help recovering or have special health needs	Skilled Nursing Care	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Limited to 25 days per Year. Preauthorization required.
	Prosthetic & Orthotic devices (appliances)	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Preauthorization required.
	Durable Medical Equipment	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Preauthorization required for items exceeding $500.
	Hospice Service	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Preauthorization required.
	Hearing aids & Cochlear implants	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Hearing aids & Cochlear implants limited to one (1) pair OR one (1) implant every 36 months. Preauthorization required.
	Rehabilitation services	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Physical therapy (PT)/occupational therapy (OT)/speech therapy (ST): Limited to 60 combined visits/year; and 1 visit per day. Chiropractic limited to 10 visits/year. Plan limitations do not apply to medically necessary services or services related to autism spectrum disorder. Preauthorization required for inpatient & ABA in cognitive therapy.
	Habilitation services	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	
	Physical Therapy (PT) & Occupational Therapy (OT) & Speech Therapy (ST)	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	
	Chiropractic care	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	
	Speech & hearing exams	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	None
	Acupuncture	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	Limited to 20 visits per Plan Year, one (1) per day.

If your child needs dental or eye care	Children's dental checkup	Not covered	Not covered	None
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
Other professional services	Radiation & chemotherapy	$25 Copay/visit Deductible does not apply	50% Coinsurance Deductible applies first	Preauthorization required
	Transplant	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Preauthorization required.
	Routine foot care	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	None
	Infusion therapy	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	Preauthorization required
	Allergy testing	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	None
	Dialysis	20% Coinsurance Deductible applies first	50% Coinsurance Deductible applies first	None
	Telehealth or Telemedicine services	No charge Deductible does not apply	50% Coinsurance Deductible applies first	Copayment, Coinsurance, and Deductible amounts will not exceed amount for comparable medical services provided through a face-to-face consultation.

Pharmacy Schedule of Benefits				
		Network Provider	**Out-of-Network Provider**	**Exclusions & Limitations and Other Important Information**
If you need Drugs to treat your Illness or condition	Generic Drugs	Retail: $4 Copay/ Prescription Deductible does not apply	50% Coinsurance Deductible applies first	Retail covers 30-day supply and mail order covers up to 90-day supply unless stated by the Formulary or the Plan Benefits. Network Provider Prescription Drug Copayment applies to the Out-of-Pocket Maximum. Member responsible for paying applicable Copay, allowable Claim amount, or the contracted rate of the Prescription, if less than the established Copay. Cost-sharing for insulin on the Formulary will not exceed $25 per Prescription for a 30-day supply. Prior Authorization is required for some Drugs. Some Prescription Drugs and/or medications are not available through the mail order service. Some Specialty Drugs are subject to Utilization Review or Prior Authorization. 30-day supply only; 90-day mail order not covered.
		Mail order: $8 Copay/ Prescription Deductible does not apply	Mail order: Not covered	
	Preferred Brand Drugs	Retail: $40 Copay/ Prescription Deductible does not apply	50% Coinsurance Deductible applies first	
		Mail order: $80 Copay/ Prescription Deductible does not apply	Mail order: Not covered	
	Non-Preferred Brands / Drugs	Retail: $75 Copay/ Prescription Deductible does not apply	50% Coinsurance Deductible applies first	
		Mail order: $150 Copay/ Prescription Deductible does not apply	Mail order: Not covered	
	Specialty Drugs	33% Coinsurance Deductible does not apply	50% Coinsurance Deductible applies first	
		Mail order: Not covered	Mail order: Not covered	